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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11910

CERTIFICATE OF DEATH

11895

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 303 SUMMIT AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward Powles Albert		First Middle Last		4. DATE OF DEATH Oct. 3 1961		Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 18 1877	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB POWLES ALBERT				14. MOTHER'S MAIDEN NAME ALICE DUNN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-7147		17. INFORMANT GEORGE D ALBERT HAGERSTOWN MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 7 days 2 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 31 1961 to Oct. 3 1961 , that (I) (we) last saw the deceased alive on Oct. 3 1961 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.				22d. ADDRESS Western Md. State Hospicare Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD	
24. FUNERAL DIRECTOR'S SIGNATURE Charles M. New				ADDRESS HAGERSTOWN MD		25a. REC'D BY REGISTRAR OCT 5 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

11010

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62 OCT 18 1977

101-10-1017

ROUTED TO: 101-10-1017
101-10-1017
101-10-1017

1 FOR STATE HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11896

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock Md</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Hancock Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Highway U.S. 40 A</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Larry Neil Adelsberger</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 18, 1947</u>	
9. AGE (In years last birthday) <u>13</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Neil Adelsberger</u>			
14. MOTHER'S MAIDEN NAME <u>Margartee Wink</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Neil Adelsberger Rural 2 Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull Intra Abdominal Hemorrhage</u> DUE TO (b) <u>812X</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child fell from wagon and was run over.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:15</u> p.m. <u>10-20-1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.) <u>Old Route 40, 2 mile East of Hancock, Wash. Md.</u>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>10-20-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10.23.61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Tonoloway Baptist</u>				22d. LOCATION (City, town, or country) (State) <u>Fulton County Penna.</u>			
23. FUNERAL DIRECTOR <u>Howard J. Gure Hancock Md</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 24 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

10

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10-10-10

10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11912

11897

1. PLACE OF DEATH e. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOONSBORO d. STREET ADDRESS NO. 2 S. MAIN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) LEROY CORNELIUS BAKER			4. DATE OF DEATH Month OCT Day 4 Year 1961		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH MAY 16 - 1908		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 4 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY TENANT FARM		11. BIRTHPLACE (County & State, or foreign country) ROXBURY WASH. CO MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME DANIEL BAKER		14. MOTHER'S MAIDEN NAME EMMA MERTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 214-32-4639		17. INFORMANT MRS ANNABELLE BAKER BOONSBORO MD.	
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral infarction, bilateral (c) Cerebral arteriosclerosis DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 10 weeks unknown			INTERVAL BETWEEN ONSET AND DEATH 4 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9-6- 1961 , to 10-4- 1961 , that (I) (we) last saw the deceased alive on 10-4- 1961 and that death occurred at 239 M, from the causes and on the date stated above.					
22a. SIGNATURE Young E. Chun M.D.			22b. DATE SIGNED Oct. 4 1961		
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN			22d. ADDRESS 1500 Pa Ave Hagerstown MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 7 - 1961		23c. NAME OF CEMETERY OR CREMATORY BENEVOLE CEMETERY	
23d. LOCATION (City, town or county) (State) BENEVOLE WASH. CO MD.		24. FUNERAL DIRECTOR'S SIGNATURE John A. Bast		25a. REC'D BY REGISTRAR OCT 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Haines					

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1912

WASHINGTON

HARRISBURG

1 MONTH

1 MONTH

WESTERN HARRISBURG STATE HOSPITAL

M. S. MAIA

LEWIS CO. L. BAKER

1912

WHITE

MAY 10 1908

RETIRED FARMER, FORMER FARM, FORDY WASH. D. C.

DANIEL BAKER

EMMA BAKER

214 32 333 WASHINGTON D. C. 20001

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1d, Film G299 11/3/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 11898

11913

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waynesboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R.D.1 Waynesboro</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>F. Barkdoll</u> Last		4. DATE OF DEATH Month <u>10/30</u> Day <u>19</u> Year <u>61</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1880</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Cattle Breeder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicolas Franklin Barkdoll</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Redd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>191-26-6801</u>		17. INFORMANT <u>Mr. Paul B. Barkdoll</u> Address <u>Waynesboro, R.D.1 Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>610X</u> DUE TO <u>VREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROSTATE HYPERTROPHY</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>10-18</u> , 19 <u>61</u> , to <u>10-30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10-30</u> , 19 <u>61</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. G. Warden</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>832 Potomac Ave HAGERSTOWN, MD.</u>					
PHYSICIAN'S NAME (Type) <u>Dr. J. G. Warden</u>		<u>832 Potomac Ave, Hagerstown, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Love</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Love</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11914					11899				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
e. COUNTY Washington					a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					b. COUNTY Washington				
c. LENGTH OF STAY IN 1b 50 years					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 914 Corbett St.					d. STREET ADDRESS 914 Corbett St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print) Jay Ralph Benedict					October 12 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH April 24, 1905				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) 56 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician					10b. KIND OF BUSINESS OR INDUSTRY Aircraft				
11. BIRTHPLACE (County & State, or foreign country) Waynesboro, Pa.					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Ira D. Benedict					14. MOTHER'S MAIDEN NAME Sarah J. Sollenberger				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO. 214-09-0227				
17. INFORMANT Mrs. Fay E. Benedict					Address Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion									
420.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) General arteriosclerosis									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Oct 11-61 , 19 61 , to Oct 12 , 19 61 , that (I) (we) last saw the deceased alive on Oct 11-61 , and that death occurred at 7:20 PM from the causes and on the date stated above.									
22a. SIGNATURE A. E. W. Dittz M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) A. E. W. Dittz									
22d. ADDRESS Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF Oct 14, 1961									
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery									
23d. LOCATION (City, town or county) (State) Hagerstown, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son									
ADDRESS Hagerstown, Md.									
25a. REC'D BY REGISTRAR Arthur S. Frazee									
25b. REGISTRAR'S SIGNATURE Arthur S. Frazee									
DATE OCT 17 '61									

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1914

Washington

Hagerstown

914 Lombard St.

50 years

914 Carroll St.

Radio

Schubert

October 12

April 25, 1902

Technician

Alfred

Myersboro, Pa.

Mr. H. Bennett

Sarah A. Hollinger

20

21--Hagerstown, Pa. Hagerstown

I

Oct. 12, 1902, Hagerstown, Pa.

Scott A. Hagerstown, Hagerstown, Pa.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11915 Item 9 Film 297 10/13/61 iwk 11900											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 Hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1012 Oak Hill Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Unnamed Baby Boy of Jacob B. Berkson				4. DATE OF DEATH Month Day Year October 8 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 7 1961		9. AGE (In years last birthday) yrs. 15		IF UNDER 1 YEAR Months Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Infant				11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob B. Berkson				14. MOTHER'S MAIDEN NAME Ann Goldstein							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Jacob B. Berkson 1012 Oak Hill Ave Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) premature DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 hours											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 10/7		20g. (County) 10/8	
21. I certify that (I) (the hospital) attended the deceased from 10/7 , 1961, to 10/8 , 1961, that (I) (we) last saw the deceased alive on 10/8 , 1961, and that death occurred at 1:40 PM from the causes and on the date stated above.											
22a. SIGNATURE H. D. Bowman, M.D.				22b. DATE SIGNED 10/9/61							
22c. PHYSICIAN'S NAME (Type) H. D. Bowman, M.D.				22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/9/61		23c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR OCT 11 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

2081293XV2

M
C

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Handwritten signature
Handwritten signature

Handwritten signature
Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11916
CERTIFICATE OF DEATH
11901

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X 211 N. Conococheague St Williamsport d. STREET ADDRESS 211 N. Conococheague St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NINA Middle PLUMA Last BOWERS		4. DATE OF DEATH Month OCT Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20 1961
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 5 Days 0	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Homes	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Daniel Cunningham	
14. MOTHER'S MAIDEN NAME Viola Dick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 212 24 5277		17. INFORMANT Daniel Davis 707 Forrest Drive Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) MYOCARDIAL INFARCTION DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 8 DAYS 8 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 10-4 - , 19 61 , to 10-20 , 19 61 , that (I) (the hospital) last saw the deceased alive on 10-20 , 19 61 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi M.D.		22b. DATE SIGNED	22c. ADDRESS 1500 PA Ave Hagerstown MD.
22d. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 23-61	23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery	23d. LOCATION (City, town or county) (State) Bakersville Md
24. FUNERAL DIRECTOR'S SIGNATURE Albert L Leaf Williamsport Md		25a. REC'D BY REGISTRAR OCT 24 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Harris

1913



Washington

Maryland

Washington

Legation

2 weeks

211 N. Conococheague St. Williamsport

Massachusetts State Hospital

211 N. Conococheague St.

Massachusetts State Hospital

211 N. Conococheague St.

Female Mate X

Oct. 20 1901

68

5 0

Housewife

Homes

Maryland

U.S.A.

Daniel Cunningham

Viola Dick

707 Warren Drive

212 24 2277 Daniel Lewis Hagerstown Md.

No

8.00

Oct. 20 1901

1.00

Oct. 20 1901

INVESTIGATION

Serial

Oct. 23-01 Hagerstown Cemetery

Hagerstown Md

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11917

CERTIFICATE OF DEATH

11902

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>45 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>51 East Antietam Street</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Washington</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> h. STREET ADDRESS <u>51 E. Antietam St.</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Clarence Bowman</u>				4. DATE OF DEATH Month Day Year <u>Oct. 14 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1896</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Wash. Cty., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Daniel Bowman</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>W.W. #1</u>		17. INFORMANT <u>Mrs. Clarence Bowman, 51 E. Antietam Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO (b) <u>Angina Pectoris</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>14 Oct 1961</u> to <u>14 Oct 1961</u> , that (I) (we) last saw the deceased alive on <u>never</u> 19, and that death occurred at <u>1030A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>F.F. Lusby</u>				22b. DATE SIGNED <u>14 Oct 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>F.F. Lusby</u>				22d. ADDRESS <u>2301 Pthoma St Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/17/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				25a. REC'D BY REGISTRAR <u>OCT 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 21 N. Locust St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 21 N. Locust St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar Mac Boyd		4. DATE OF DEATH Month October Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891 Dec. 31, 1961
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Package Store	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John E. Boyd	
14. MOTHER'S MAIDEN NAME Nanny Duffey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. W. W. 1		17. INFORMANT Preston Martin Address Hagerstown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immediate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/10/61 19....., to 10/10/61 19....., that (I) (we) last saw the deceased alive on 10/10/61 19....., and that death occurred at 10:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 10/10/61	
22c. PHYSICIAN'S NAME (Type) Ralph F. Young		22d. ADDRESS Williamsport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 12, 61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR OCT 13 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE William S. Harris	

OCT 13 '61

(M)

1.318

Washington

Hagerstown

Life

Hagerstown

21 W. Locust St.

21 N. Locust St.

Wm. W. Loe

Wm. W. Loe

October 10

Wm. W. Loe

Dec. 11, 1911

62

Wm. W. Loe

Wm. W. Loe

Hagerstown, Md.

John E. Loe

John E. Loe

Wm. W. Loe

Wm. W. Loe

The copy of the paper was made

Wm. W. Loe

Wm. W. Loe

Dec. 12, 1911

Hagerstown, Md.

Dec. 12, 1911

Dec. 12, 1911

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11919
11904
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nagerstown Rural</u>		c. LENGTH OF STAY IN 1b <u>5 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Joseph</u> Middle <u>Brady</u> Last		4. DATE OF DEATH <u>Oct.</u> Month <u>3</u> Day <u>1961</u> Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Darby J. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Marcella Scally</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Frostburg, Md.</u> Address <u>Mrs. Vincent Bollino, 10 Frost Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Failure</u> 421.4 DUE TO (b) <u>Chr. Valvular Dis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>2 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 25, 1961</u> to <u>Oct 3, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 2, 1961</u> , and that death occurred on <u>Oct 3, 1961</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David R. Brewer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		22d. ADDRESS <u>Clear Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-5-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Montsant</u>		25a. REC'D BY REGISTRAR <u>Hafer Funeral Home</u> DATE <u>OCT 9 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

17

1918

STATE OF TEXAS

COUNTY OF DALLAS

Know all men by these presents, that I, David M. Brown, of the County of Dallas, State of Texas, for and in consideration of the sum of Five Dollars, to John A. Brown, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said John A. Brown, his heirs and assigns forever, all that certain Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the corners of which are as follows, to-wit:

Beginning at the South corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the corners of which are as follows, to-wit:

Beginning at the South corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the corners of which are as follows, to-wit:

Beginning at the South corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the corners of which are as follows, to-wit:

Beginning at the South corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the corners of which are as follows, to-wit:

Beginning at the South corner of the Tract of land, situate in the County of Dallas, State of Texas, containing Five Acres, more or less, the corners of which are as follows, to-wit:

1
FOR STATE
HEALTH DEPT.

TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11905														
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY in lb life time d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 225 1/2 N Jonathan Street					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland d. STREET ADDRESS 225 1/2 N. Jonathan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Daniel Leo Brooks					4. DATE OF DEATH Month Oct Day 9 Year 19 61									
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 2 1907		9. AGE (In years last birthday) 53 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown Md.			12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Daniel G. Brooks					14. MOTHER'S MAIDEN NAME Lora R. William									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO.					17. INFORMANT Address Mrs. Cho B. Overton Hagerstown md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Hypertrophy Marked 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Congestion & Edema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Recent														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Dr. E. W. Ditto, Jr. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-11-61 Address (Street, city, town, or county)														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10-12-1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			22d. LOCATION (City, town, or country) (State) Hagerstown Maryland						
23. FUNERAL DIRECTOR ADDRESS John R. Watson Jr. Hagerstown Md.						24a. REC'D BY REGISTRAR DATE OCT 16 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume						

TOP SECRET

(M)

(A)

232 Jonathan Street
Hagerstown, Maryland 21740

Colonel Daniel Lee Brooks
Dec 2 1961

Hagerstown, Md.
John A. Williams

1000 1/2 South Washington Ave.
Hagerstown, Md.

United States Army
Hagerstown, Md.

10-11-61

10-11-61

10-11-61

10-11-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
11921 CERTIFICATE OF DEATH 11906															
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 48 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 713 Sunset Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 713 Sunset Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) FREDERICK JOSEPH BROWN				4. DATE OF DEATH October 10 1961				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH February 27, 1895 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Roundhouse Forman Railroad				10b. KIND OF BUSINESS OR INDUSTRY Emmitsburg, Maryland				11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frederick L. Brown				14. MOTHER'S MAIDEN NAME Bertha M. Riley											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W.W. I 705-10-5981				17. INFORMANT Mrs. Gladys E. Brown Address Hagerstown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) Atherosclerotic heart disease DUE TO (c) 5 yr + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None												INTERVAL BETWEEN ONSET AND DEATH 2 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 12, 1954 to Oct. 10, 1961 , that (I) (we) last saw the deceased alive on Oct. 10, 1961 , and that death occurred at 12:55 PM , from the causes and on the date stated above.															
22a. SIGNATURE L. L. Packard Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/10/61							
22c. PHYSICIAN'S NAME (Type) L. L. Packard Jr.				22d. ADDRESS Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/12/1961				23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rye				ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 13 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

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Г. С. Соловьев

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
11922
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11967
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) Courtney Cloud BUCK		4. DATE OF DEATH Month 10 Day 10 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILK CONTROL SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY BALTO. HEALTH DEPT.	
11. BIRTHPLACE (County & State, or foreign country) FRONT ROYAL, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELLIOTT M. BUCK		14. MOTHER'S MAIDEN NAME DELIA CLOUD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Courtney E. Norford		Address Balto. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 181-0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) CARCINOMA OF BLADDER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PYELONEPHRITIS		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 29, 1961 to Oct 10, 1961 , that (I) also last saw the deceased alive on Oct 10, 1961 , and that death occurred at 10:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi		22b. DATE SIGNED 10-20	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-14-61	
23c. NAME OF CEMETERY OR CREMATORY PROSPECT Hill		23d. LOCATION (City, town or county) (State) FRONT ROYAL, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE MADDOX FUNERAL HOME G. R. Maddox, Jr.		25a. REC'D BY REGISTRAR FRONT ROYAL, VA. DATE OCT 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

11222

(M)

CASHINGTON

WARRAND

FREDERICK

HAGERSTOWN 2 WEEKS

FREDERICK

WESTERN MARYLAND STATE HOSPITAL

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COMBINATION CLOAK RUCK

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MILK CONTACT MARYLAND HEALTH DEPT. FRONT ROYAL VA

ERINOT M RUCK DENIA CLOUD

(J)

NO.

Front Royal, Va

ERINOT 10-24-21
MILK CONTACT MARYLAND HEALTH DEPT. FRONT ROYAL VA

PROSPECT HILL
FRONT ROYAL, VA

FRONT ROYAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11923 CERTIFICATE OF DEATH 11908											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>						c. LENGTH OF STAY IN lb <u>Life</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					
						d. STREET ADDRESS <u>911 G Main Ave.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond</u> <u>Autler</u> <u>Butts</u>						4. DATE OF DEATH Month Day Year <u>October</u> <u>30</u> <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 29, 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Eng. Power Plant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. R.R.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Franklin Butts</u>						14. MOTHER'S MAIDEN NAME <u>Nora J. Autler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>217-10-2510</u>					
17. INFORMANT <u>Mrs. R. A. Butts</u>						Address <u>911 G Main Ave. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Thrombosis of cerebral artery</u> (c) <u>11.9.61 M. 2.19.61</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 30, 1961</u> to <u>Oct 30 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 30, 1961</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Edson B. Moody</u> M.D.						22b. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>					
22c. PHYSICIAN'S NAME (Type) <u>Edson B. Moody M.D.</u>						22d. DATE SIGNED <u>10/31/61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11/2/61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>		
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>						ADDRESS <u>Hagerstown, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 3 '61</u>		
						25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>					

15023

(M)

(1)

Walter D. Stewart

San Francisco, California

11/15/51

Dear Mr. Stewart:

Thank you for your letter of 11/15/51.

Very truly yours,

W.D.S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1
11924
11909
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY in 1b Life				d. STREET ADDRESS 39 E. Franklin St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jack Martin Byers				4. DATE OF DEATH Month Oct. Day 1 Year 19 61			
5. SEX male		6. COLOR OR RACE whitie		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1898	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 03 Days 03		IF UNDER 24 HRS. Hours 03 Min. 03			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk				10b. KIND OF BUSINESS OR INDUSTRY city water Dept.			
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY? Estelle Davis			
13. FATHER'S NAME Walter B. Byers				14. MOTHER'S MAIDEN NAME Estelle Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 215-26-7872			
17. INFORMANT Mrs. Elizabeth Y. Byers, Hagerstown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199X DUE TO IMMEDIATE CAUSE (a) Carcinoma entire throat and chin Conditions, if any, which gave rise to immediate cause (b) 199X (c) 199X cause last. (c) 199X				INTERVAL BETWEEN ONSET AND DEATH 21 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/1/61 , 19 61 , to 10/1/61 , 19 61 , that (I) (we) last saw the deceased alive on 10/1/61 , 19 61 , and that death occurred at 12 M. from the causes and on the date stated above.							
22a. SIGNATURE Scott F. Minnich M.D.				22b. DATE SIGNED 10/2/61			
22c. PHYSICIAN'S NAME (Type) S. Earl Young, M.D.				22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Oct. 4, 61		23c. NAME OF CEMETERY OR CREMATORY Rose hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 4 '61			
ADDRESS Scott F. Minnich & Son, Hagerstown, Md.				25b. REGISTRAR'S SIGNATURE Walter E. Pinner			



Washington

Washington

Life

Washington

Washington County Hospital

33 E. Franklin St.

Jack

Jack

Jack

Oct. 1

male

white

May 7, 1938

03

chief

city water dept.

Washington, Md.

Walter B. Myers

Residence Davis

no

215-26-7872 Mrs. Elizabeth Y. Myers, Washington, D.C.

Handwritten signature

burial

Oct. 8, 61

Washington County

Washington, Md.

Scott E. Minnich & Son, Washington, Md. 200

11925
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 11911

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) CONOCOCHIEAGUE				c. LENGTH OF STAY IN 1b 14 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 1 MAIN ST.							
3. NAME OF DECEASED (Type or print) First Middle Last LYDIA PLEASANT CARBAUGH				4. DATE OF DEATH Month Day Year OCT. 4 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 8, 1871	
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES				10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK			
11. BIRTHPLACE (State or foreign country) FULTON CO. PA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHNATHAN SHIVES				14. MOTHER'S MAIDEN NAME JANE PECK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT FRANK T. MCDONALD, HAGERSTOWN, MD.				18. ADDRESS 58 WAYSIDE AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 444 X DUE TO (b) Hypertensive Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1961 to Oct 4, 1961 , that (I) (we) last saw the deceased alive on Oct 3, 1961 , and that death occurred at 1230 PM , from the causes and on the date stated above.							
22a. SIGNATURE David R. Brewer				22b. DATE SIGNED 10/4/61			
22c. PHYSICIAN'S NAME (Type) David R. Brewer				22d. ADDRESS Clear Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/6/61		23c. NAME OF CEMETERY OR CREMATORY ANTIETAM NATIONAL CEM.		23d. LOCATION (City, town, or county) (State) SHARPSBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland				25. RECORD BY REGISTRAR Oct 9 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11926

11912

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS 839 Anthony Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Lynn Last Caulkins				4. DATE OF DEATH Month 10 Day 1 Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-61	
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		11. IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Roger Williams Caulkins				14. MOTHER'S MAIDEN NAME Elizabeth Jane Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT Roger W. Caulkins Address Waynesboro, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Intra-uterine) DUE TO (b) Premature rupture of the membranes the Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. mother 3 weeks prior to delivery DUE TO (c) mother 3 weeks prior to delivery							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 30 hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9/30/1961 to 10/1/1961 , that (I) (we) last saw the deceased alive on 10/1/1961 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. M. Bacon Jr.				22b. DATE SIGNED 10/3/61			
22c. PHYSICIAN'S NAME (Type) A. M. Bacon, Jr.				22d. ADDRESS 101 King St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 10-3-61		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	
23d. LOCATION (City, town, or county) (State) Waynesboro Pa.							
24. FUNERAL DIRECTOR'S SIGNATURE Margaret Rowland Clearspring, Md.				25a. REC'D BY REGISTRAR DATE OCT 5 '61		25b. REGISTRAR'S SIGNATURE Charles S. Finner	

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The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11927
11913
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - MT. BRIER d. STREET ADDRESS KEEDYSVILLE MD. R.I.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE WASHINGTON CLARK First Middle Last		4. DATE OF DEATH OCTOBER 2, 1961 Month Day Year		9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY R.R. Co.		11. BIRTHPLACE (County & State, or foreign country) MT. BRIER WASH. CO. MD. U.S.A.	
13. FATHER'S NAME GEORGE CLARK		14. MOTHER'S MAIDEN NAME MARGARET WRIGHT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 220-10-3745		17. INFORMANT MRS. SARAH CLARK		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertensive cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Competitive heart failure	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1957, to Oct 2, 1961, that (I) (we) last saw the deceased alive on Oct 2, 1961, and that death occurred at 10 A.M., from the causes and on the date stated above.					
22a. SIGNATURE Heur		22b. SIGNATURE JOSEPH SECONDARI		22c. ADDRESS BOONSBORO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 4, 1961		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
23d. LOCATION (City, town or county) HAGERSTOWN WASH. CO. MD.		23e. REC'D BY REGISTRAR DATE OCT 10 '61		23f. REGISTRAR'S SIGNATURE Charles J. Thomas	

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The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11928
CERTIFICATE OF DEATH

11914

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Rural Williamsport # 2 c. LENGTH OF STAY IN b 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Extine Road Williamsport RFD #2		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport RFD #2 d. STREET ADDRESS Extine Rd. Williamsport RFD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theodore Cleveland Clipp		4. DATE OF DEATH Oct. 31 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 4 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Building Blocks	9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months 7 Days 26 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME David Clipp		14. MOTHER'S MAIDEN NAME Ida Huff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 235 12 1022	
17. INFORMANT Extine Road		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A c. myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Immediate (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/31/61 to 10/31/61 , that (I) (we) last saw the deceased alive on 10/31/61 , and that death occurred at 11/1/61 from the causes and on the date stated above.			
22a. SIGNATURE Leaf & Young M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 11/1/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 3-61	23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Albert L Leaf Williamsport, Md		25a. REC'D BY REGISTRAR NOV 2 '61 25b. REGISTRAR'S SIGNATURE William S. France	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11915

1. PLACE OF DEATH COUNTY <u>Washington County</u> <u>WASD Hagerstown</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle Pa. P.O. #2.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Mem. Conv. Hosp.</u>		d. STREET ADDRESS <u>75x-3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>A.</u> Last <u>Coble</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1871</u>
9. AGE (In years last birthday) yrs. <u>83</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB A. COBLE</u>		14. MOTHER'S MAIDEN NAME <u>ARABELLA ZARGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>186-30-5708</u>	
17. INFORMANT <u>MRS. JACOB A. COBLE</u>		Address <u>R.R. #2 GREENCASTLE, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>indefinite</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Disease, cerebral & generalized</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> 19 <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-9</u> 19 <u>61</u> to <u>death</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-20</u> 19 <u>61</u> , and that death occurred at <u>5:42</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Keagle</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. KEAGLE</u>		22d. ADDRESS <u>HAGERSTOWN, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 24, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>COBLES CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. THOMAS TWP, FRANKLIN Co, PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Sellers, Chambersburg, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO FATAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11930

CERTIFICATE OF DEATH

11916

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS Ravenwood Height	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAE Middle SMITH Last CONRAD				4. DATE OF DEATH Month October Day 27 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 30, 1883	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pulaski, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Fielding Smith				14. MOTHER'S MAIDEN NAME Mary Lowman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ross C. Copley Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rt hip						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1961 to Oct 27, 1961 , that (I) (we) last saw the deceased alive on Oct 27, 1961 , and that death occurred at 2 AM , from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison M.D.				22b. DATE SIGNED 10/30/61			
22c. PHYSICIAN'S NAME (Type) Paul Harrison M.D.				22d. ADDRESS Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/1961		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Ringer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 1 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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revisions:

Received 10 June 2008

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Regional Director

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References

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6. *Conclusions*

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6/30/14 Real Estate Company

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• 2 • notes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11931

CERTIFICATE OF DEATH

11917

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 1 Hancock Md.</u>	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>COONROD</u> Last <u>COONROD</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.18.1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Bedford County Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Coonrod</u>		14. MOTHER'S MAIDEN NAME <u>Emma Clingerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marvin Bohrer Rural 1 Clyde N.Y.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Cervix uteri</u> DUE TO (c) <u>9 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23, 1961</u> to <u>Oct 25, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 25, 1961</u> and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D.		22b. DATE SIGNED <u>Oct. 25 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10.29.61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rose Wayne County N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hone Hancock Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hone</u>			

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Washington, D.C.

Department of State

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11932

CERTIFICATE OF DEATH

11918

1. PLACE OF DEATH e. COUNTY <u>Washington</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DETOUR</u> g. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>John P. COSDEN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joshua S. Cosden</u>		14. MOTHER'S MAIDEN NAME <u>Anna Procter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-20-7334</u>	
17. INFORMANT <u>Ralph Cosden</u>		Address <u>Detour, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>LOBULAR PNEUMONIA</u> DUE TO (b) <u>CARCINOMA OF PROSTATE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>10 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25</u> 19 <u>61</u> to <u>Oct 12</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 12</u> 19 <u>61</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Antonio U. Pallagrosi</u>		22b. DATE SIGNED <u>3-20</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>		22d. ADDRESS <u>1500 Penna. Ave Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u>		25a. REC'D BY REGISTRAR <u>Francis W. Miller</u>	
25b. REGISTRAR'S SIGNATURE <u>2101 Frederick Ave.</u>		25c. DATE <u>OCT 16 '61</u>	

(M)

1133

11/11/18

London, 11/11/18

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst.

in relation to the above.

I am sorry to hear that you are unable to visit London at the present time.

I am, however, glad to hear that you are still in good health.

I am, Sir, very respectfully,
Yours faithfully,

John P. Cooper

Secretary to the Committee on the Administration of the Government of India

and of the Council of the Government of India

at the India Office, Whitehall, London, W.C.

I am, Sir, very respectfully,
Yours faithfully,

John P. Cooper

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11933

CERTIFICATE OF DEATH

Item 2 Film G298 10/25/61 ink

11919

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> <u>13 MONTHS</u> c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>REEDER NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> <u>WASHINGTON</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> <u>15 X 2</u> d. STREET ADDRESS <u>16214 Vorlich Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA B. COULTER</u> First Middle Last 4. DATE OF DEATH <u>OCTOBER - 13 - 1961</u> Month Day Year		9. AGE (In years if UNDER 1 YEAR last birthday) <u>78</u> yrs. Months <u>11</u> Days <u>1</u> Hours <u></u> Min. <u></u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PITTSBURGH PENNA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTIAN BERGIER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>JESSE C. COULTER</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>general</u> <u>10/13/61</u> to <u>10/13/61</u> , that (I) (we) last saw the deceased alive on <u>10/13/61</u> , and that death occurred <u>11:45 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>G.W. LeVan</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>G.W. LeVan</u> 22d. ADDRESS <u>Boonsboro</u>		22b. DATE SIGNED <u>10/13/61</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>OCT. 15, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> ADDRESS <u>Boonsboro MD.</u> 25a. REC'D BY REGISTRAR <u>DATE OCT 19 '61</u> 25b. REGISTRAR'S SIGNATURE	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11920											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. c. LENGTH OF STAY IN 1b Life time d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS 45 Blooms Alley						
3. NAME OF DECEASED (Type or print) Walter James Cross					4. DATE OF DEATH Month Day Year Oct 30 1961						
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10 1925		9. AGE (In years last birthday) 36			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME Walter J. Cross					14. MOTHER'S MAIDEN NAME Ella Woodyard						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes					16. SOCIAL SECURITY NO. 1225-14-6224					17. INFORMANT Mrs. Ella Mack Address 410 Sumans Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia 581.0 DUE TO Cardiac hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty Change of Liver, marked (c) Pulmonary Congestion & Edema Aspiration of Vomitus (Agonal)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature]					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Dr. E. W. H. T. P. J.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					DATE SIGNED 11/4/61						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 11-2-1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) Hagerstown Md.		
23. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md.					24a. REC'D BY REGISTRAR DATE NOV 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans				

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Washington County Hospital
Hagerstown, Md.
Date: _____
To: _____
From: _____
Subject: _____
Physician: _____
Nurse: _____
Diet: _____
Medication: _____
X-ray: _____
Laboratory: _____
Special: _____
Remarks: _____
Signature: _____
Date: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11921											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				d. STREET ADDRESS 1317 Oak Hill Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 101 W. Lee Street						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROY			First Middle Last DANZER, JR.			4. DATE OF DEATH October 6 1961			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 27, 1913		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary-Treasure				10b. KIND OF BUSINESS OR INDUSTRY Metal Fabrication Company		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Roy Danzer, Sr.						14. MOTHER'S MAIDEN NAME Mary Skiles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II				16. SOCIAL SECURITY NO. 214-09-0197		17. INFORMANT Mrs. Jeanette Darner Danzer Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombotic Occlusion Of Ant. Decending Coronary 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Atherosclerosis, Severe (c) Cardiac Hypertrophy										INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-7-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) Hagerstown Maryland					
23. FUNERAL DIRECTOR Suter - Houzer Funeral Home				ADDRESS Hagerstown, Maryland				24a. REC'D BY REGISTRAR ACT 9 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1936

CERTIFICATE OF DEATH

11922

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X SPIELMANS STATION 'RURAL' d. STREET ADDRESS FAIRPLAY MD. R. 1	
3. NAME OF DECEASED (Type or print) JOSEPH M. DELAUDER		4. DATE OF DEATH OCTOBER 30 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 24 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	9. AGE (In years last birthday) 86 yrs.
13. FATHER'S NAME JOHN DELAUDER		11. BIRTHPLACE (County & State, or foreign country) BREATHESVILLE WASH. CO. MD. U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		12. CITIZEN OF WHAT COUNTRY? U.S.A	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT RALPH DELAUDER FAIRPLAY MD. R. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Congestive Heart failure DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from Oct 26, 1961 to Oct 30, 1961 , that (i) (we) last saw the deceased alive on Oct 30, 1961 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE M. E. Byrkit		22b. DATE SIGNED 10-31-61	
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit		22d. ADDRESS 28 W Potomac Weymouth	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 1 1961	
23c. NAME OF CEMETERY OR CREMATORY BAKERSVILLE CEMETERY		23d. LOCATION (City, town or county) (State) BAKERSVILLE MD (WASH. CO.)	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Bast		25a. REC'D BY REGISTRAR DATE NOV 2 '61	
ADDRESS BOONSBORO MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11937 CERTIFICATE OF DEATH 11923											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 601 Frederick St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAYNE IDLA DICK						4. DATE OF DEATH October 23 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19 1895		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Mapleville Wash Co Md				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Kennedy						14. MOTHER'S MAIDEN NAME Jennie Butts					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Henry J. Dick 601 Frederick St Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cavernous Sinus Thrombosis DUE TO (b) Staph. infection about eyes DUE TO (c) Septicemia (staphylococcic) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 23, 1961 to Oct. 23, 1961 , that (I) (we) last saw the deceased alive on Oct. 23, 1961 , and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE R.A. Bell						22b. DATE SIGNED 10-25-61		22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.			
22d. ADDRESS 119 N. Potomac St. Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hall Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						25a. REGISTERED BY REGISTRAR Oct 27 61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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may be signed by the funeral director, by the funeral director, and completely filled out by the funeral director. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11938

11924

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RPI - Hagerstown</u>		d. STREET ADDRESS <u>RPI - Hagerstown md.</u>	
3. NAME OF DECEASED (Type or print) <u>William E. Ebersole</u> First Middle Last		4. DATE OF DEATH <u>Oct. 30</u> 19 <u>61</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1892</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>near Hagerstown, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Ebersole</u>		14. MOTHER'S MAIDEN NAME <u>Retiza Grabill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>203-10-2941</u>	
17. INFORMANT <u>Mrs. Rachel Ebersole</u> Address <u>RPI Hagerstown, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u> <u>1 Yr.</u> <u>10 Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-18-59</u> , 19 <u>59</u> , to <u>10-30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-2-61</u> , 19 <u>61</u> , and that death occurred at <u>5:30 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		ADDRESS (Street, city or town, state) <u>Smithsburg, Maryland</u> DATE SIGNED <u>10-30-61</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u>		<u>Smithsburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		22b. DATE THEREOF <u>11/1/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Upton Brethren Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Upton, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnick</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>Nov 2 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Clairmont H. Hume</u>	

CERTIFICATE OF DEATH

11331

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		10/15/1878	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH	
101 - 10th Street, Wausau, Wis.		Farmer		Heart Disease		Home	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
11/15/1918		10:30 AM		101.5		110	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF CERTIFICATE		TIME OF CERTIFICATE		PLACE OF CERTIFICATE		OFFICE OF CERTIFICATE	
11/15/1918		10:30 AM		Home		Wausau, Wis.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11939

CERTIFICATE OF DEATH

Reg. Dist. No.

11925

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stagers town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>1 Maugansville, Md</u>	
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>E.</u> Last <u>Eshleman</u>		4. DATE OF DEATH <u>Oct. 24</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24, 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Clara Railing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Geo. S. Eshleman - Maugansville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO <u>Dichetes</u> (c) <u>Dichetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-1-1961</u> to <u>10-24-1961</u> , that I last saw the deceased alive on <u>10-24-1961</u> , and that death occurred at <u>9:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. E. Wittig</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>	
PHYSICIAN'S NAME (Type) <u>Dr E W Wittig</u>		DATE SIGNED <u>10/25/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>10/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Geartoss Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich - Greencastle Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 27 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christina E. Hume</u>	

CERTIFICATE OF DEATH

11032

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>New York City</u></p>	
<p>6. Date of death: <u>Dec 10, 1945</u></p>	
<p>7. Place of death: <u>Home</u></p>	
<p>8. Cause of death: <u>Heart Disease</u></p>	
<p>9. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>10. Underlying cause: <u>Coronary Artery Disease</u></p>	
<p>11. Manner of death: <u>Natural</u></p>	
<p>12. Signature of physician: <u>[Signature]</u></p>	
<p>13. Signature of registrar: <u>[Signature]</u></p>	

11032

11032

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11926

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOONSBORO MD. R. 2</u>			d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN EMORY FAULDERS</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER - 14 - 1961</u>		
5. SEX <u>MALIE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE - 12 - 1881</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days <u>4 2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR MT. LENA WASH. CO. MD. U.S.A.</u>	
13. FATHER'S NAME <u>JOHN E. FAULDERS</u>			14. MOTHER'S MAIDEN NAME <u>RACHAEL COX</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-10-3397</u>		17. INFORMANT Address <u>MRS. NANCY FAULDERS BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Aneurysm</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio Vascular System</u> (a), stating the underlying cause last. DUE TO (c) <u>General arterio sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>A. E. W. J.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/16/61</u>	
EXAMINER'S NAME (Type) <u>A. E. W. J.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 17. 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u>		ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

OR - DITTO

M

X

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11941

CERTIFICATE OF DEATH

11927

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 40 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 603 W. CHURCH ST.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 603 W. CHURCH ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle VINCENT Last FRITZ		4. DATE OF DEATH Month OCTOBER Day 16 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1879
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT MFG CO. PENNSYLVANIA	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN THEODORE FRITZ		14. MOTHER'S MAIDEN NAME CATHERINE ELLEN HORNBAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) NO		16. SOCIAL SECURITY NO. 214-09-2298	
17. INFORMANT MRS. MARGARET FRITZ		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis of left middle cerebral art 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Atherosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal pneumonia		INTERVAL BETWEEN ONSET AND DEATH 6 months year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Feb 1961 to 16 Oct 1961 , that (I) (we) last saw the deceased alive on 14 Oct 1961 , and that death occurred at 4:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Arthur S. Hoachlander M.D.		22b. DATE SIGNED 10/17/61	
22c. PHYSICIAN'S NAME (Type) Arthur S. Hoachlander		22d. ADDRESS 1154 W. Wash. St. Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/18/61	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.	
24 FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR Arthur S. Hoachlander	
25b. REGISTRAR'S SIGNATURE		DATE OCT 19 '61	

CERTIFICATE OF MARRIAGE

11011

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 14 Film G297 10/9/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

11928

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>10X-1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elsie Mae Gank</u>		4. DATE OF DEATH Month Day Year <u>Oct. 5 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1916</u>
9. AGE (In years lost birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia, Tucker Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Carr</u>		14. MOTHER'S MAIDEN NAME <u>W. N. Summerfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Jacob Overcash</u> Address <u>Sabillasville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 5</u> , 19 <u>61</u> , to <u>Oct. 5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>61</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W. N. Fender</u> M.D.			
PHYSICIAN'S NAME (Type) <u>W. N. Fender, M.D.</u>		<u>218 N. Potomac St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Masontown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Masontown, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Groves</u> ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 9 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kiana</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11943

CERTIFICATE OF DEATH

11929

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MD. STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>1078 SPRUCE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Minnie Myrtle Gilkey</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> , Year <u>1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/18/1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>7</u> Min. <u>14</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>JESSE S. A. CHLER</u>				14. MOTHER'S MAIDEN NAME <u>KATE L. RUSSMAN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>24-09-5113B</u>				17. INFORMANT <u>MR. GROVER M. CHLER</u> Address <u>HAGERSTOWN MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO <u>181.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>abdominal carcinomatosis</u> DUE TO <u>carcinoma of bladder</u> (c) <u>5 mos.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>unknown</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Hypertension (2) Benign nephrosclerosis</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>Sept. 12, 1961</u> to <u>Oct. 20, 1961</u> , that <u>(1) (two)</u> last saw the deceased alive on <u>Oct. 20, 1961</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>				22b. DATE SIGNED <u>Oct. 20, 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>				22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/24/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>				23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN, MD.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norman, Hagerstown, Md.</u>				ADDRESS <u>HAGERSTOWN, MD.</u>				25a. REC'D BY REGISTRAR <u>DACT 23 '61</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>											

11383

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11944

11930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. BOYER - WILSON
 135 N. POTOMAC ST.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>40 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>109 ELM ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>109 ELM ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARROLL EDGAR GRIFFITH</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>3</u> Year <u>1961</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPTEMBER 20 1908</u> 9. AGE (In years last birthday) <u>53</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MECHANIC - GARAGE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>NEAR KEEDYSVILLE WASH. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FLOYD W. GRIFFITH</u> 14. MOTHER'S MAIDEN NAME <u>FLORA MAE LEWIS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 16. SOCIAL SECURITY NO. <u>214-09-5005</u> 17. INFORMANT <u>MRS. ELLA LOU GRIFFITH</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema & Hypoproteinemia</u> (b) <u>Left & Right ventricular Failure</u> (c) <u>Passive congestion Liver & Renal Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>60 days</u> <u>1 year</u> <u>years</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>1955</u> <u>Oct. 2</u> <u>61</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 5</u> , 19 <u>55</u> , to <u>Oct. 2</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct. 5</u> , 19 <u>55</u> , and that death occurred <u>Oct. 2</u> , 19 <u>61</u> , at <u>6:45 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>D. J. Boyer</u> 22c. PHYSICIAN'S NAME (Type) <u>D. J. Boyer, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>135 N. Potomac Street, Hagerstown, Md.</u>		22b. DATE SIGNED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, RE-OVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT-6-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		ADDRESS <u>BOONSBORO MD</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

(M)

100 W. 2nd St.

(1)

11944

WASHINGTON

REGISTERED

100 E. 2nd St.

CARROLL EDGAR GRIFFITH

WHITE

Retired Mechanic - GEORGE -

LOYD W. GRIFFITH

W. W. J.

2100 2nd St. N.W. ELLA L. GRIFFITH

GEORGE W. LEWIS

2100 2nd St. N.W. 20

EDGAR GRIFFITH

100 E. 2nd St.

REGISTERED

WASHINGTON

OCT-6-1941 Rose Hill Cemetery

10000000 MD

OCT 10 11

WASHINGTON

1

4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11945

CERTIFICATE OF DEATH

Reg. Dist. 11931

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES HENRY GRIM				4. DATE OF DEATH Month Day Year October 26, 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1892	
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant (Retired) Gen. Store		11. BIRTHPLACE (State or foreign country) Dargan, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Robert Grim				14. MOTHER'S MAIDEN NAME Annie F. Huff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-8650		17. INFORMANT Everette F. Grim Address Sharpsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) 12 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 19 49 , to Oct. 27 , 19 61 that I last saw the deceased alive on October 23 , 19 61 , and that death occurred at 2:45 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 10/29/61 ACTUAL SIGNATURE Walter H. Shealy M.D. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/61		22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or county) (State) Samples Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Cocker				24a. REC'D BY REGISTRAR DATE OCT 31 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11283

LAST NAME FIRST NAME MIDDLE NAME		SEX AGE DATE OF BIRTH	
PLACE OF BIRTH COUNTRY OF BIRTH		OCCUPATION INDUSTRY	
MARITAL STATUS DATE OF MARRIAGE		PREVIOUS MARRIAGES DATE OF DEATH	
PLACE OF DEATH CITY COUNTY STATE		CAUSE OF DEATH ICD-10 CODE	
MEDICAL HISTORY PREVIOUS ILLNESSES SURGERIES		PATHOLOGICAL FINDINGS AUTOPSY	
SIGNATURE OF PHYSICIAN DATE		SIGNATURE OF REGISTRAR DATE	

(M)

(1)

THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, HAS RECEIVED THE FOLLOWING REPORT OF DEATH:

NAME: [Name]
 SEX: [Sex]
 AGE: [Age]
 DATE OF BIRTH: [Date]
 PLACE OF BIRTH: [Place]
 COUNTRY OF BIRTH: [Country]
 OCCUPATION: [Occupation]
 INDUSTRY: [Industry]
 MARITAL STATUS: [Status]
 DATE OF MARRIAGE: [Date]
 PREVIOUS MARRIAGES: [List]
 DATE OF DEATH: [Date]
 PLACE OF DEATH: [Place]
 CITY: [City]
 COUNTY: [County]
 STATE: [State]
 CAUSE OF DEATH: [Cause]
 ICD-10 CODE: [Code]
 MEDICAL HISTORY: [History]
 PREVIOUS ILLNESSES: [List]
 SURGERIES: [List]
 PATHOLOGICAL FINDINGS: [Findings]
 AUTOPSY: [Result]
 SIGNATURE OF PHYSICIAN: [Signature]
 DATE: [Date]
 SIGNATURE OF REGISTRAR: [Signature]
 DATE: [Date]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11946

CERTIFICATE OF DEATH

Reg. Dist. No. 11939

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
c. LENGTH OF STAY IN 1b <u>5 hrs</u>		d. STREET ADDRESS <u>1154 Antizzen St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospit</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>May</u> Last <u>Grove</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Jefferson Co., W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Zackariah Taylor Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Amanda, Isabelle Wilt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Niece Mrs Ann Fleming Wooddy</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock (cardio-vascular collapse)</u> <u>585X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cholecystitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. ft.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 8, 1960</u> to <u>Oct 26, 1961</u> , that I last saw the deceased alive on <u>Oct 26, 1961</u> , and that death occurred at <u>7:57 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>10-26-61</u> ACTUAL SIGNATURE <u>Max E Byrkit</u> M.D. PHYSICIAN'S NAME (Type) <u>Max E. Byrkit Williamsport Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edge Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Charles Town, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Donald Cables</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u>	
ADDRESS <u>Asperly Ferry</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Huns</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in 1b 3 Yrs		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 302 Jefferson St	
e. STATE Maryland		f. COUNTY Washington		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA GLADYS HALE		4. DATE OF DEATH Month Day Year October 23 1961		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Month Day Year July 18 1872		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jonas R. Spaugh		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No --		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Martha Kelbaugh		Address 302 Jefferson St Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Coronary atherosclerosis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7 , 19 61 , to Oct 23 , 19 61 , that (I) (we) last saw the deceased alive on Oct 23 , 19 61 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE S. DNEY NOVEMBER		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-24-61	
22c. PHYSICIAN'S NAME (Type) S. DNEY NOVEMBER		22d. ADDRESS Funkstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/61		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City, town or county) (State) Funkstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR DATE OCT 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Krasa			



11111

Washington

Washington

303 Jefferson St

IDA

Remains to be

Housewife

John A. B. Spence

He

Hone

Washington

Washington

303 Jefferson St

HADP

July 8 1975

John A. B. Spence

He

USA

Washington 7 22 00

Andrew K. Collins, Hagerstown, Md.

Barrel 101-2/51

Washington 7 22 00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11948

CERTIFICATE OF DEATH

Item 9 Film G299 11/1/61 iwk

11934

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hager town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 619 N. Locust St., Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		d. STREET ADDRESS 1 Hagerstown	
3. NAME OF DECEASED (Type or print) First MARY Middle CASILDA Last HANSBROUGH		4. DATE OF DEATH Month OCT Day 23 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-1879
9. AGE (In years last birthday) 82 3/4 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dress maker		10b. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (County & State, or foreign country) Front Royal, Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andrew Hackett	
14. MOTHER'S MAIDEN NAME Mary Kingsley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Alice M. Hansbrough Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) FRACTURE OF LEFT HIP (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Malignant melanoma of left cheek unexcised		INTERVAL BETWEEN ONSET AND DEATH 3 Days 4 Months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FELL WHILE AT HOME		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) FELL WHILE AT HOME	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6-23 p.m. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) HAGERSTOWN WASHINGTON MD	
21. I certify that (I) (this hospital) attended the deceased from 7-13-61, to 10-23-61, that (I) (we) last saw the deceased alive on 10-23-61, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi		22b. DATE SIGNED 10-23-61	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 Pa Ave Hagerstown MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 10-26-61	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret K. Rowland		25a. REC'D BY REGISTRAR OCT 25 '61	
ADDRESS Clear Spring, Md.		25b. REGISTRAR'S SIGNATURE Carling S. Finner	

11913

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10 OCT 58

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11949 CERTIFICATE OF DEATH 11935

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>16 days</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>R.F.D. # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Milford</u> Last <u>Heil</u>				4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>19 61</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Heil</u>				14. MOTHER'S MAIDEN NAME <u>Clara Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-9369</u>		17. INFORMANT <u>Mrs. Lottie Heil</u> Address <u>Hagerstown, Md. R3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis, Severe</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Hypertrophy Prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>14 days</u> <u>Several years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-25</u> <u>1961</u> to <u>10-28</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>10-27</u> <u>1961</u> , and that death occurred at <u>3P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-31-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Magnum R. Rowland</u>				ADDRESS <u>Clearspring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

11303

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CH 11303

MADE IN U.S.A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11936									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN lb life time d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 146 N. Jonathan Street.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland d. STREET ADDRESS 146 N Jonathan Street. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Clyde Russell Hill					4. DATE OF DEATH Oct 5 19 61				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 31 1889		9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 213-12-7235		17. INFORMANT Washington County Welfare Board Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE [Signature]					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-7-61				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Oct 9 1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Md.		
23. FUNERAL DIRECTOR John R Watson Jr Hagerstown Md. ADDRESS					24a. REC'D BY REGISTRAR Oct 11 '61 DATE		24b. REGISTRAR'S SIGNATURE [Signature]		

11250

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Washington, D.C.
Mr. J. Edgar Hoover
Director, Federal Bureau of Investigation
U.S. Department of Justice

Dear Sir:
Reference is made to your letter of the 10th instant, in which you request information regarding the activities of the "Black Legion" in the District of Columbia.

The Bureau has been advised that the "Black Legion" is a term used to designate a group of individuals who are active in the District of Columbia, and who are engaged in various criminal activities, including the sale of narcotics and the operation of gambling establishments.

It is noted that the "Black Legion" is a group of individuals who are active in the District of Columbia, and who are engaged in various criminal activities, including the sale of narcotics and the operation of gambling establishments.

The Bureau has been advised that the "Black Legion" is a group of individuals who are active in the District of Columbia, and who are engaged in various criminal activities, including the sale of narcotics and the operation of gambling establishments.

Very truly yours,
J. Edgar Hoover
Director

Enclosed for the Bureau are two copies of a report of the activities of the "Black Legion" in the District of Columbia, dated 10/10/35.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11951											
11937											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring R # 2</u> c. LENGTH OF STAY IN 1b <u>5 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Srt Pauls Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring</u> d. STREET ADDRESS <u>St Pauls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ALLAN LYNN HOLLAR</u>						4. DATE OF DEATH <u>Oct 23 1961</u> Month <u>Oct</u> Day <u>23</u> Year <u>19</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 8 1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Novelty Store</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Winchester Frederick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hollar</u>						14. MOTHER'S MAIDEN NAME <u>Lavinia Lynn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-----</u>						16. SOCIAL SECURITY NO. <u>816-30-3728</u>		17. INFORMANT <u>Mrs Viola F. Hollar Clear Spring R #2</u> Address <u>Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Occlusion</u> DUE TO (b) <u>2 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Acute Virus Infection</u> DUE TO (d) <u>2 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Virus Infection</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 15</u> to <u>Oct 22, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 18, 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>David R. Brewer</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/23/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>						22d. ADDRESS <u>Clear Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>						ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Richard H. Hume</u>	
						DATE <u>OCT-27-61</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11952

11938

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>1426 West Washington St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>DERR</u> Last <u>Hull</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1961</u>					
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 24, 1876</u>			
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Walter B. McCoy</u>				14. MOTHER'S MAIDEN NAME <u>Clara Ardinger</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Louisa Hull</u> Address <u>426 W. Washington</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebro Vascular Disease</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-1-</u> <u>1961</u> to <u>10-23</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>10-22</u> <u>1961</u> , and that death occurred at <u>3A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>A. E. W. Dett</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A. E. W. Dett</u>				22d. ADDRESS <u>Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Wolf Williamsport, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>			

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11523

THE STATE OF TEXAS

Vol. 40-11, Honorable Secretary

COMMISSION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11953

CERTIFICATE OF DEATH

Reg. Dist. No. 11939

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			c. LENGTH OF STAY IN 1b <u>Most of life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>03</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>WOODPOINT AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LENNA</u> Middle <u>VIRGINIA G.</u> Last <u>HUTZEL</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1896</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Barber Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Gainer</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Burley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-4786</u>		17. INFORMANT Address <u>Elmer C. Hutzell Woodpoint Ave. Hagerstown, Md. R #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MESENTERIC THROMBOSIS</u> (c) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 + HRS.</u> <u>7 + YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 OCTOBER, 1961</u> , to <u>7 OCTOBER, 1961</u> , that I last saw the deceased alive on <u>7 OCTOBER, 1961</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>218 N. Potomac St. HAGERSTOWN, MARYLAND</u> DATE SIGNED <u>7 OCT. 1961</u>							
ACTUAL SIGNATURE <u>W. N. Fender</u>		M.D. <u>218 N. Potomac St. HAGERSTOWN, MARYLAND</u>					
PHYSICIAN'S NAME (Type) <u>W. N. Fender</u>		M.D. <u>HAGERSTOWN, MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. O. Hoot</u>				ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>			

1
FOR STATE
HEALTH. DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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1

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11940									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dargan				
c. LENGTH OF STAY IN 1b 9 years					d. STREET ADDRESS RFD#1, Harpers Ferry, W.Va.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 50 yds. off Dargan Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First GORDON Middle OWEN Last Ingram					4. DATE OF DEATH Month October 13, Year 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1952		9. AGE (In years last birthday) 9 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Dargan, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Granville James Ingram					14. MOTHER'S MAIDEN NAME Genevieve Pauline Norris				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Granville Ingram RFD #1, Harpers Ferry, West Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Gunshot Wound involving entire Left side of Face and Head. DUE TO (b) Face and Head. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH Instant
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another boy				
20c. TIME OF INJURY Month, Day, Year 5:00PM 10-13 1961			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Dargan (County) Washington (State) Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dr. E.W. Ditto, Jr.					M.D. DATE SIGNED 10/13/61				
EXAMINER'S NAME (Type) Dr. E.W. Ditto, Jr.					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/61		22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or country) (State) Samples Manor, Maryland			
23. FUNERAL DIRECTOR J. DONALD EACKIES,					24a. REC'D BY REGISTRAR DATE OCT 19 '61		24b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

11934

M

K

General would involving entire left side of

Face and head.

Shot by another boy

10-25 of 1934

Dr. E. M. Dineen, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

<div> <div>1955</div> <div>1941</div> </div> <div> <div>1</div> <div>M</div> <div>I</div> </div>																	
<div> <div>1. PLACE OF DEATH</div> <div> <div>a. COUNTY</div> <div>Washington</div> </div> <div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Hagerstown</div> </div> <div> <div>c. LENGTH OF STAY IN 1b</div> <div>27 years</div> </div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Washington County Hospital</div> </div> </div>						<div> <div>2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)</div> <div> <div>a. STATE</div> <div>Maryland</div> </div> <div> <div>b. COUNTY</div> <div>Washington</div> </div> <div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Hagerstown</div> </div> <div> <div>d. STREET ADDRESS</div> <div>804 Hamilton Blvd.</div> </div> <div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> </div>											
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>OTIS</div> </div>			<div> <div>4. DATE OF DEATH</div> <div>October</div> </div>			<div> <div>5. SEX</div> <div>Male</div> </div>			<div> <div>6. COLOR OR RACE</div> <div>White</div> </div>			<div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div>					
<div> <div>8. DATE OF BIRTH</div> <div>April 27, 1899</div> </div>			<div> <div>9. AGE (In years last birthday)</div> <div>62 yrs.</div> </div>			<div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Retired Salesman</div> </div>			<div> <div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Lawrenceville, Virginia</div> </div>			<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>					
<div> <div>13. FATHER'S NAME</div> <div>William Ivey</div> </div>						<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>? Welton</div> </div>											
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>no</div> </div>						<div> <div>16. SOCIAL SECURITY NO.</div> <div>214-09-6520</div> </div>						<div> <div>17. INFORMANT</div> <div>Mr. Greer McD. Jones</div> </div>					
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div> <div>IMMEDIATE CAUSE (a)</div> <div>Ventricular Fibrillation</div> </div> <div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.</div> <div> <div>(b)</div> <div>Arteriosclerotic heart disease</div> </div> <div> <div>(c)</div> <div>Renal Nephrosclerosis</div> </div> </div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div></div> </div> </div> </div>																	
<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>																	
<div> <div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> </div>																	
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>19</div> </div>			<div> <div>20d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not While <input type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input type="checkbox"/></div> </div>			<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> </div>			<div> <div>20f. (City or town)</div> <div>Clarksville</div> </div>			<div> <div>(County)</div> <div></div> </div>					
<div> <div>21. I certify that (1) (this hospital) attended the deceased from Oct 26, 1961 to Oct 28, 1961, that (1) (we) last saw the deceased alive on Oct 28, 1961, and that death occurred at 7:45 P.M. from the causes and on the date stated above.</div> </div>																	
<div> <div>22a. SIGNATURE</div> <div>Paul Harrison</div> </div>						<div> <div>22b. DATE SIGNED</div> <div>10/29/61</div> </div>											
<div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>Paul Harrison M. D.</div> </div>						<div> <div>22d. ADDRESS</div> <div>318 N. Potomac Street</div> <div>Hagerstown, Md.</div> </div>											
<div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>			<div> <div>23b. DATE THEREOF</div> <div>11/1/1961</div> </div>			<div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Oak Hurst Cemetery</div> </div>			<div> <div>23d. LOCATION (City, town or county)</div> <div>Clarksville</div> </div>			<div> <div>(State)</div> <div>Va.</div> </div>					
<div> <div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>Suter - Rouzer Funeral Home</div> </div>						<div> <div>25a. REC'D BY REGISTRAR</div> <div>NOV 1 '61</div> </div>						<div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Krause</div> </div>					

M

11922

Washington

Station

27 years

Station

Washington County located

801 Hamilton Ave.

October

1922

White

James Coleman

Shipping Supply

Lawrenceville, Virginia

Willam River

Station

21-08-22

Mr. J. C. Jones Lawrenceville, Va.

and William H. H.

Mr. J. C. Jones

1/1/22

Lawrenceville

Lawrenceville

Mr. J. C. Jones Lawrenceville, Va.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11956

11942

1. PLACE OF DEATH a. COUNTY Washington Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Iyr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. d. STREET ADDRESS 1816 E. Oldtown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George B. Jones <i>George Benjamin Jones</i>		4. DATE OF DEATH Month Day Year Oct. 5 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 24, 1911 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) Cumberland Md.
13. FATHER'S NAME Trevor Jones		14. MOTHER'S MAIDEN NAME Emma McKenney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-4824	
17. INFORMANT Nellie Jones		Address 1816 Oldtown Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Atrophic lateral sclerosis (c) 19 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 356.1		INTERVAL BETWEEN ONSET AND DEATH 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11, 1961 to October 5, 1961 , that (I) (we) last saw the deceased alive on October 5, 1961 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED October 5, 1961	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-8-61	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR OCT 10 61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17352

(M)

Residence of

Washington

177

Washington State - 1911

George Jones

December 1, 1911

1911

1911

1911

(L)

1911

1911

1911

1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11957

11943

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>510 Chestnut St.</u>				d. STREET ADDRESS <u>510 Chestnut St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Clinton</u> Last <u>Karn</u>				4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1881</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpehter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Burkittsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William C. Karn</u>				14. MOTHER'S MAIDEN NAME <u>Cora Whipp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-8524</u>		17. INFORMANT <u>C.R. Karn 214 Ridge Ave. Waynesboro, Penna.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-1-61</u> to <u>10-15-61</u> , that (I) (we) last saw the deceased alive on <u>9-27-61</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. B. B. [Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR. W. H. T. T. J.</u>				22d. ADDRESS <u>Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 18 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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11221

Washington

Department

710 Cleveland St.

of

State

Comptroller

William C. Brown

No

11221

Washington

Department

710 Cleveland St.

of

State

80

March 27, 1911

Comptroller

John Brown

211-11-11221 C. Brown and William C. Brown

W. C. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11958

11944

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 5 MOS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN	
3. NAME OF DECEASED (Type or print) First Anna Middle Last KEIRS		4. DATE OF DEATH Month 10 - Day 31 - Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (In years last birthday) 83 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KEIRS		14. MOTHER'S MAIDEN NAME JANET MORTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. VERA NAVE, 104 W. MAIN ST., FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia 142.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, right submaxillary gland / 5 months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH one week		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 5-23-1961 to 10-31-1961 that (I) (we) last saw the deceased alive on 10-31-1961 and that death occurred at 12:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE SIGNED 10-31-1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-1961	
23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J.R. Durst		25a. REC'D BY REGISTRAR DATE NOV 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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JOHN E. LING

JOHN E. LING

JOHN E. LING, JR., 200 N. MAIN ST.,
BOSTON, MASS.

JOHN E. LING, JR., 200 N. MAIN ST.,
BOSTON, MASS.

1938

JOHN E. LING, JR., 200 N. MAIN ST.,
BOSTON, MASS.

JOHN E. LING, JR., 200 N. MAIN ST.,
BOSTON, MASS.

JOHN E. LING, JR., 200 N. MAIN ST.,
BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11959

CERTIFICATE OF DEATH

11945

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>9860 Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lawson</u> First <u>---</u> Middle <u>Keller</u> Last		4. DATE OF DEATH <u>October 17</u> Month <u>17</u> Day <u>1961</u> Year					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>April 14, 1897</u>		9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ordinance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro, Penna.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Lawson Keller</u>			14. MOTHER'S MAIDEN NAME <u>Annie Sheeley</u> (Not certain of spelling) Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>175-03-2915</u>		17. INFORMANT <u>Mrs. Lawson Keller 9860 Main St. Damascus, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Carcinoma Pancreas with</u> (a), stating the underlying (c) <u>multiple metastasis - Prostate Hypertrophy</u> causa lesi. <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>15 Oct 1961</u> to <u>17 Oct 1961</u> , that (I) (we) saw the deceased alive on <u>16 Oct 1961</u> , and that death occurred at <u>6:00</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank E Brumback</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>18 Oct 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank E Brumback</u>		22d. ADDRESS <u>170 west Washington ST</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Horst</u>		ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 20 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11922

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Washington County Hospital
Washington, D.C.
April 11, 1947
Dear Sirs:
Enclosed for you are two copies of a letterhead memorandum from the Federal Bureau of Investigation, dated and captioned as above.
Very truly yours,
J. Edgar Hoover
Director

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11946
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cavetown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Theodore Last Kendall				4. DATE OF DEATH Month Oct. Day 20 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1876	9. AGE (In years lost birthday) yrs. 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) blacksmith		10b. KIND OF BUSINESS OR INDUSTRY blacksmith shop		11. BIRTHPLACE (State or foreign country) Pleasant Valley, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William I. Kendall				14. MOTHER'S MAIDEN NAME Susan Brunner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-36-0323		17. INFORMANT Jason L. Kendall, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 15 Days 10 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Smithsburg, Md.	(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1/3 1957 , to 10/20 1961 , that (I) (we) last saw the deceased alive on 10/20 1961 and that death occurred at 3 M, from the causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess				22b. ADDRESS Smithsburg, Md.			
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.				22d. DATE SIGNED 10/21/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-23-61		23c. NAME OF CEMETERY OR CREMATORY Welty's Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				25a. REC'D BY REGISTRAR Oct 24 '61		25b. REGISTRAR'S SIGNATURE Carlton L. Hume	

11288

THE WHITE OX BRAND

CAUTION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boonsboro d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LORENA JEAN KEPLINGER		4. DATE OF DEATH Month Day Year October 5 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant	9. AGE (In years last birthday) yrs. 5 IF UNDER 1 YEAR Months Days 5 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl R. Emrick		14. MOTHER'S MAIDEN NAME Joyce C. Keplinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joyce C. Keplinger		Address 631 West Franklin St Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Of Vomitus DUE TO 754.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) Passive Congestion Of Viscera			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-7-61 Address (Street, city, town, or county)			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		EXAMINER'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/61	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR Andrew K. Coffman		24a. REC'D BY REGISTRAR OCT 11 '61	
ADDRESS Hagerstown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11962
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11948

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>839 W. Washington St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>CORA SMITH KING</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>19 61</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 9 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (Country & State, or foreign country) <u>Franklin Co Pa. Blue Ridge Summit</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Eliz (Unknown)</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>312-14-7491</u>				17. INFORMANT <u>Henry K. King</u> Address <u>839 W. Washington St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 days</u> DUE TO (c) <u>4 days</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10-16-1961</u> to <u>10-23-1961</u> , that (I) (we) last saw the deceased alive on <u>10-22-1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Little</u>				22d. ADDRESS <u>[Signature]</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/25/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Harbaughs Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rouzersville Franklin Co Pa.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							
								DATE <u>OCT 27 '61</u>											

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[Faint, mostly illegible text and handwriting covering the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY in it 70 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 69 ELIZABETH ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY HAMILTON KRETZER		4. DATE OF DEATH OCTOBER 24 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/24/1872
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TOOL MAKER		10b. KIND OF BUSINESS OR INDUSTRY CEMENT MFG. CO.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. KRETZER		14. MOTHER'S MAIDEN NAME ELIZABETH DOYLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-7858	
17. INFORMANT MR. HARRY W. KRETZER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with A-V Block and Stokes-Adams Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 (b) Generalized Arteriosclerosis. (c) Generalized Arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 3, 1960 to Oct. 24, 1961 , that (I) (we) last saw the deceased alive on Oct. 24, 1961 , and that death occurred at 7P.M. from the causes and on the date stated above.			
22a. SIGNATURE R.A. Bell		22b. DATE SIGNED Oct. 25, 1961.	
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		22d. ADDRESS 119 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/27/61	
23c. NAME OF CEMETERY OR CREMATORY BEAVER CREEK LUTHERAN		23d. LOCATION (City, town or county) (State) WASHINGTON COUNTY MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment		25. REC'D BY REGISTRAR OCT 30 '61	
25a. REGISTRAR'S SIGNATURE Arthur S. Hume		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11964

CERTIFICATE OF DEATH

11950

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN it <u>THREE MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>BRTN. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LENORA McLAUGHLIN LAKIN</u>		4. DATE OF DEATH <u>OCTOBER - 17 - 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER - 17 - 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELWOOD McLAUGHLIN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE ANKENY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROBERT F. LAKIN</u>		Address <u>BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete heart block and ventricular failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fracture left hip</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>Oct 17</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 17</u> , 19 <u>61</u> , and that death occurred at <u>12:30 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Stauffer</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u></u>		22d. ADDRESS <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 20, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>NEAR CLEARSPRING MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baird</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
ADDRESS <u>BOONSBORO MD.</u>		DATE <u>OCT 24 '61</u>	

11884

UNITED STATES OF AMERICA

1900

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WASHINGTON

HOOPER TOWN

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HOOPER TOWN

WASH. CO. MARYLAND

WASH. CO. MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, very filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11965 CERTIFICATE OF DEATH 11951											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock c. LENGTH OF STAY IN b 68 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Lashley				4. DATE OF DEATH Month 10 Day 4 Year 1961							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1888		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Penna/Glass Corp. Allegany Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles G Lashley				14. MOTHER'S MAIDEN NAME Rebecca J Nycum							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216.14.6471				17. INFORMANT Mrs Rose E Lashley Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia 20414 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 21 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (1) (this hospital) attended the deceased from July 1959 to Oct. 4, 1961 , that (1) (we) last saw the deceased alive on Oct. 2, 1961 , and that death occurred at 6:30am from the causes and on the date stated above.											
22a. SIGNATURE F.B. Thomas III M.D.				22b. DATE SIGNED 10-6-61							
22c. PHYSICIAN'S NAME (Type) Frank B. Thomas III MD				22d. ADDRESS Hancock, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7.61		23c. NAME OF CEMETERY OR CREMATORY Rehobeth Methodist		23d. LOCATION (City, town or county) (State) Rural Fulton County Penna.					
24. FUNERAL DIRECTOR'S SIGNATURE Howard F. Grove Hancock Md.				25a. REC'D BY REGISTRAR OCT 10 '61				25b. REGISTRAR'S SIGNATURE Clifton S. Howard			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11966

11952

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Downsville		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Downsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Downsville				d. STREET ADDRESS Downsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl Downey Long				4. DATE OF DEATH Month Oct. Day 8 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26 1884		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 11 Days 11	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery & Hardware		11. BIRTHPLACE (County & State, or foreign country) Downsville Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Long				14. MOTHER'S MAIDEN NAME Ida C. Welty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I 219 20 0129		17. INFORMANT Address Mrs. Kathleen Long Downsville Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) Obesity						INTERVAL BETWEEN ONSET AND DEATH 5 min 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 7, 1958 to Oct 8, 1961 , that (I) (we) last saw the deceased alive on Oct 7, 1961 , and that death occurred at 9:30 M, from the causes and on the date stated above.							
22a. SIGNATURE M. E. Byrkit				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-10-61	
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit				22d. ADDRESS Williamsport Md			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF Oct. 13-61		23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		23d. LOCATION (City, town or county) (State) Bakersville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Jennie C. Leaf Williamsport Md				25a. REC'D BY REGISTRAR DATE OCT 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11002

Washington

Downsville

Downsville

Earl

Male White

Store Owner

Thomas Long

Yes

Downsville

Downsville

Downsville

Long

Oct. 26 1884

Downsville Mo.

Ida C. Kelly

40 yrs.

Downey

Property &
Holds

Oct. 2

Nov 11

USA

Washington

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Would you like to see the photograph of the person who was with you on the night of the murder?

Serial 100-13-61 Bakerville Cemetery Bakerville Mo.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11967 CERTIFICATE OF DEATH 11953											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOOKS BORO RT 2</u> c. LENGTH OF STAY IN 1b <u>4 YRS 4 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAHNEY NERBY MEN. HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BRUNSWICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1025 - 2</u> d. STREET ADDRESS <u>111 EAST A ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>EMMA</u> <u>CECELIA</u> <u>MARTIN</u>			4. DATE OF DEATH <u>10</u> <u>19</u> <u>1961</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></u>			8. DATE OF BIRTH <u>5/7/73</u>			9. AGE (In years last birthday) <u>88</u> yrs.			IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAIL ROAD</u>			11. BIRTHPLACE (County & State, or foreign country) <u>BERKLEY W. VA.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>JOHN THOMAS MARTIN</u>			14. MOTHER'S MAIDEN NAME <u>MARGARET CECILIA CONWAY</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> <u>1961</u> to <u>Oct 20</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 19</u> <u>1961</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>G. W. Heelan</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/20/61</u> 22c. PHYSICIAN'S NAME (Type) <u>G. W. Heelan</u> 22d. ADDRESS <u>Brownston</u> 23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10-23-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SAINT MARKS</u> 23d. LOCATION (City, town or county) (State) <u>PETERSVILLE MD</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Heelan</u> ADDRESS <u>BRUNSWICK, MARYLAND</u> 25a. REC'D BY REGISTRAR DATE <u>OCT 26 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>											

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Handwritten signature or name.

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TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11968

11954

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1417 W. Church St., extd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Edward Last Mayhugh		4. DATE OF DEATH Month 10 Day 26 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1916
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Fairchilds	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Clayton Mayhugh		14. MOTHER'S MAIDEN NAME Susan Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-16-1247	
17. INFORMANT Susan Mayhugh		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder 181-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-8-61 to 10-26-61 that (I) (we) last saw the deceased alive on 10-26-61 and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph C. Crisp MD		22b. DATE SIGNED 10-28-61	
22c. PHYSICIAN'S NAME (Type) JOSEPH-C. CRISP MD		22d. ADDRESS 115 King St. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-29-61	
23c. NAME OF CEMETERY OR CREMATORY Beautiful View		23d. LOCATION (City, town, or county) (State) State Line Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		25a. REC'D BY REGISTRAR DATE OCT 31 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus		25c. ADDRESS Clear Spring, Md.	

11203

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-11-81 BY 1043
1043

1 FOR STATE HEALTH DEPT.

is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11955	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mangonsville</u>				c. LENGTH OF STAY in 1b <u>5 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u>				d. STREET ADDRESS <u>514 E. Philadelphia St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main St. R # 4 Hagerstown</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Franklin</u> Last <u>McKinley</u>						4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1867</u>		9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Tolna, York Co. Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel McKinley</u>						14. MOTHER'S MAIDEN NAME <u>Mariah Orwig</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>199-07-7362</u>		17. INFORMANT <u>Mr. Harvey M. Miller 111 W. Washington St.</u> Address <u>Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Senility</u> (c) <u> </u> DUE TO (e), stating the underlying cause last. (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: /Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>10-28-61</u>		
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>10/31/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Stewartstown, York Co. Penna.</u>	
23. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>						ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

Wm. A. Hark

11308

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10-10-1

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11970

11956

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville d. STREET ADDRESS North Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD METZ		4. DATE OF DEATH OCT. 6 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR 4 Months 5 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (County & State, or foreign country) Downsville Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Christian Metz	
14. MOTHER'S MAIDEN NAME Prudence (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. 212 14 6397		17. INFORMANT Mrs. Gladys Metz Address N. St. Maugansville Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) PYELONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIAC HYPERTROPHY - CHRONIC RHEUMATIC HEART DISEASE			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from 5-29- 19 61 , to 10-6- 19 61 , that (I) (the deceased) last saw the deceased alive on 10-6- 19 61 , and that death occurred at 5 AM , from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallacrossi M.D.		22b. DATE SIGNED 1500 Pa Ave Hagerstown MD.	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLACROSSI		22d. ADDRESS 1500 Pa Ave Hagerstown MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 8-61	
23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		23d. LOCATION (City, town or county) (State) Bakersville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf ADDRESS Williamport Md		25a. REC'D BY REGISTRAR OCT 9 '61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

(M)

11370

Washington

Kentland

Washington

Hamartown

5 month

Hamartown

Western Kentucky State Hospital

North Street

Wichman

Edward

WETS

Oct

Male White May 30 1884 77

Lebor

Born

Hamartown Mo.

1884

Christian News

Providence (Unknown)

212 14 0397 Mrs. Wanda News N. St. Hamartown Mo. Kentucky

(I)

Burial Oct. 2-61 Bakerville Cemetery Bakerville Mo.

Wagon & horse

Antonia A. Bell

26

2-14

10-2-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11971											
11957											
1. PLACE OF DEATH e. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 473 N. Potomac Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MATHIAS First PETER Middle MÖLLER, JR. Last						4. DATE OF DEATH October 20 19 61 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1902		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President				10b. KIND OF BUSINESS OR INDUSTRY Pipe Organ Manufacture				11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Mathias P. Moller, Sr.						14. MOTHER'S MAIDEN NAME Julia M. Greenlund					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Hilda Moller Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO 4/6 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Rheumatic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH 1 min + 39 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic Heart Disease											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 24, 1953 to Oct. 20, 1961 , that (I) (we) last saw the deceased alive on Oct. 20, 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Clord A. Hoffman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 21-61			
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman						22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE OCT 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11571



Washington

Washington

Washington County Hospital

11571, Washington Co.

Washington

Washington

Washington, D.C.

Washington

Washington

Washington

White

X

May 8, 1902

Side View
Front View

Portrait

Washington, D.C.

Portrait, 1/2 length, 3/4 length

Portrait, 1/2 length, 3/4 length

Portrait, 1/2 length, 3/4 length

no

10/23/1901

Rose Hill Cemetery

Portrait

Portrait - former funeral home Washington, D.C.

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11972

11958

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>8 Hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown (Greenberry Hills)</u> d. STREET ADDRESS <u>1728 Timberlane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCIE PATRICIA MOORE</u> 4. DATE OF DEATH Month Day Year <u>October 4 19 61</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 27 1958</u> 9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, foreign country) <u>Oregon Coos Bay Coos Co</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William G. Moore</u> 14. MOTHER'S MAIDEN NAME <u>Gertrude S. Scheuppert</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>William G. Moore</u> Address <u>1728 Timberlane Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> <u>340.0</u> DUE TO (b) <u>Meningitis - Hemophilic Influenzae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>10/3/61</u> to <u>10/4/61</u> , that (I) (we) last saw the deceased alive on <u>10/3/61</u> , and that death occurred <u>4:40 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A.M. Bacon Jr.</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A.M. Bacon, Jr.</u>				22d. ADDRESS <u>101 King St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown M.d.</u>				25a. REC'D BY REGISTRAR <u>OCT 9 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11973

CERTIFICATE OF DEATH

11959

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 70 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1311 Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lily Irene Morin		4. DATE OF DEATH Last Month Day Year October 22 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1883
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Franklin County, Pa.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Jacob L. Eckstine		14. MOTHER'S MAIDEN NAME Eliza V. Startzman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	17. INFORMANT Mrs. Norma M. Foltz
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Mesenteric vascular occlusion DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 4-6 years		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/11 1961 to 10/22 1961, that (I) (we) last saw the deceased alive on 10/22 1961, and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 10/23/61	22c. PHYSICIAN'S NAME (Type) George Jennings
22d. ADDRESS Hagerstown, Md.		22e. REC'D BY REGISTRAR 136 W. Washington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-24-61	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR OCT 24 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

11073



Washington

Washington

Washington

in person

20 years

Washington

Washington County Hospital

Lily Irene Kohn

October 22

Female White

October 1, 1905

John W. Kohn

own home

Franklin County, Pa.

John L. Bokstein

John L. Bokstein

--- Mrs. Kohn - 1001 R. 2

Washington County Hospital

Oct 1 1905

Book L. Minnich & Son, Hagerstown, Md. 10-22-01
Hagerstown, Md. 10-22-01

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11974

11960

Item 8 Film G-299 11/6/61 1wk

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Morgan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Rest Home		d. STREET ADDRESS c/o Postmaster	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Henry Last Moser		4. DATE OF DEATH Month Oct. Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 Aug. 25, 1961
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen. Store	
11. BIRTHPLACE (State or foreign country) Morgan County, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel D. Moser		14. MOTHER'S MAIDEN NAME Amanda Largent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs Mildred L. Kline, Paw Paw, W. Va.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 25 yrs 25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign tumor middle lobe of left lung.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 10-19 1961 , to 10-27 1961 , that (I) was last saw the deceased alive on 10-27 1961 , and that death occurred at 5:55 M, from the causes and on the date stated above.			
22a. SIGNATURE Frank B. Thomas M.D.		22b. DATE SIGNED 10-30-61	
22c. PHYSICIAN'S NAME (Type) Frank B. Thomas, MD		22d. ADDRESS Hancock, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/61	
23c. NAME OF CEMETERY OR CREMATORY Camp Hill		23d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE PARKS-JOHNSON CO. BERKELEY SPRINGS, W. VA.		25a. REC'D BY REGISTRAR NOV 2 '61	
25b. REGISTRAR'S SIGNATURE Charles L. Kline			

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UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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11961
MAY 10 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 14 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOS.		d. STREET ADDRESS 662 OAK RIDGE DRIVE	
3. NAME OF DECEASED (Type or print) Charles Scott Naille		4. DATE OF DEATH October 10, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1878
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLAY NAILL		14. MOTHER'S MAIDEN NAME CATHERINE I. WEEKLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-10-2249	
17. INFORMANT MRS. DAISY M. NAILL		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 minute unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 3, 1961 to Dec. 10, 1961 , that (I) (we) last saw the deceased alive on October 10, 1961 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED Oct. 10, 1961	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/12/61	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CHURCH CEM.		23d. LOCATION (City, town or county) (State) TOWN CREEK MD.	
24. FUNERAL DIRECTOR'S SIGNATURE SHIRAZ ROULET FUNERAL HOME R. Franklin Ringer		25a. REC'D BY REGISTRAR DATE OCT 13 '61	
ADDRESS HAGERSTOWN, MD		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11976

CERTIFICATE OF DEATH

11962

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u> c. LENGTH OF STAY IN 1b <u>33 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8 Fredrick Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u> d. STREET ADDRESS <u>8 Fredrick Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE FRANCES NALLEY</u>			4. DATE OF DEATH Month Day Year <u>October 3 19 61</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>December 30, 1898</u>		9. AGE (In years last birthday) <u>62 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Funkstown, Wash. Co. Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Frank R. Brewer</u>					
14. MOTHER'S MAIDEN NAME <u>Minnie O. Stouffer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Charles H. Nalley, 8 Fredrick Road, Funkstown, Maryland.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>420.0 Atherosclerotic Heart Disease.</u> (c) <u>Sudden death.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 21, 19 59</u> to <u>Aug. 14, 19 61</u> that (I) (we) last saw the deceased alive on <u>Aug. 14, 19 61</u> and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R.A. Bell</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>Oct. 4, 1961.</u>					
22c. PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>		22d. ADDRESS <u>Hagerstown, Maryland.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Funkstown Wash Co Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Maryland</u>					
25a. REC'D BY REGISTRAR <u>OCT 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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R. A. Bell, ...

Oct 3 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11977					11963									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY		Washington			a. STATE		Maryland							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Hagerstown			b. COUNTY		Washington							
c. LENGTH OF STAY IN 1b		Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
2200 Rowland Ave.					1 2200 Rowland Ave.									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last Charles Albert Palmer					Month Day Year October 1 1961									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		August 22, 1886		75 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
Salesman		Household appliances		Washington Co. Md.		USA								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
David Palmer					Molly Jacobs									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No					214-09-1365					A.C. Palmer 1216 Glenwood Ave. Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Sudden death.				
420.1 DUE TO														
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)										Generalized Arteriosclerosis.				
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
None.														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19														
21. I certify that (I) (this hospital) attended the deceased from Sudden death, to Oct. 1, 1961, that (I) (we) last saw the deceased alive on Aug. 7, 1961, and that death occurred at 8 M, from the causes and on the date stated above.														
22a. SIGNATURE					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/2/61					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
R. A. Bell, M.D.					Hagerstown, Maryland.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			10/3/61		Rest Haven Cemetery			Hagerstown Md.						
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
Rest Haven Funeral Chapel Hagerstown, Md.					OCT 3 '61		Arthur S. Frank							
Wm. G. Horok														

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11978

CERTIFICATE OF DEATH

11964

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in lb <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>613 Hagerstown</u> d. STREET ADDRESS <u>11204 Virginia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EVERETT EDWIN PRATT</u>				4. DATE OF DEATH <u>October 23 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 5 1917</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Peoples Drug Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Erie Erie Co Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edwin O. Pratt</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Dorman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>W.W. # 2</u>				16. SOCIAL SECURITY NO. <u>195-03-5485</u>			
17. INFORMANT <u>Mrs Pearl S. Pratt</u>				Address <u>1204 Virginia Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> (b) <u>Coronary artery thrombosis</u> (c) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/29 1961</u> to <u>10/23 1961</u> that (I) (we) last saw the deceased alive on <u>10/23 1961</u> and that death occurred at <u>1205 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George Jennings</u>				22b. DATE SIGNED <u>10/24/61</u>		22c. PHYSICIAN'S NAME (Type) <u>George Jennings</u>	
22d. ADDRESS <u>136 W. Washington St. Hagerstown, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				24b. ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Krupp</u>				25c. DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

41873

M

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Germany, early 19th century

George Thompson

1843

1843

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11979					11965						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		Washington			a. STATE		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown			b. COUNTY		Washington				
c. LENGTH OF STAY in 1b		50 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
36 Nottingham Road					1230 Winter Street						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
ETHEL			MAY		PRESGRAVES				Month Day Year		
									October 13 1961		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		February 28, 1889		72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife								Winchester, Virginia		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
William Fletcher					Alice Roe						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)					16. SOCIAL SECURITY NO.					17. INFORMANT	
no										Mr. Morris Fletcher Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Recent	
334X DUE TO Hemiplegia											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										10 yrs	
DUE TO General Arteriosclerosis											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED	
Hour a.m. p.m. 19										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1-1961, to 10-13-1961, that (I) (we) last saw the deceased alive on 9-22-1961, and that death occurred at 4:14 P.M. from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
Dr. BB / [Signature] M.D.										[Signature] 10-13-61	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
Dr. E. W. J. [Signature]										Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
Burial										10/15/1961	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
Rest Haven Cemetery										Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR	
Suter, Rouzer Funeral Home										25b. REGISTRAR'S SIGNATURE	
Hagerstown, Md.										DOCT 18 '61	

11310

(M)

Location

Department

38 Nottingham Road

REPORT

WY

SPRINGFIELD

Location

(1)

February 28, 1989

x

White

Female

Housewife

Winchester, Virginia

U.S.A.

William Jackson

Alice Lee

Mr. William Jackson, Winchester, Virginia

no

(I)

[Faint handwritten notes and signatures]

[Faint handwritten notes and signatures]

10/1/89 Last seen January

Enter - Housewife, 38 Nottingham Road, Winchester, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11980

11966

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Hagerstown	
c. LENGTH OF STAY in 1b 6 days		d. STREET ADDRESS P.O.Box Route 3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Geneva Last Reid		4. DATE OF DEATH Month October Day 14 , Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1886
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75	IF UNDER 24 HRS. Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Downsville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Whitney		14. MOTHER'S MAIDEN NAME N.F.N. Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT James A. Reid, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Breast With Metastasis To Brain. 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1961, to Oct. 14, 1961 that (I) (we) last saw the deceased alive on Oct. 14, 1961, and that death occurred at 5:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 10-16-61	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-17-61	
23c. NAME OF CEMETERY OR CREMATORY rose hill cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR OCT 18 '61	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

M

11220

Washington

Bakersfield, California

May

June

September

Washington County Hospital

P.O. Box 1000

Catharine, Nevada

Reid

October 14, 1911

Female, white

Sept. 2, 1888

Bakersfield, California

Lawrenceville, N.C.

James, white

Sept. 2, 1888

Moore

James A. Reid, Bakersfield, Cal.

none

Department of Forest & Fish Research, Bureau of Fish and Game, Washington, D.C.

Jan. 1, 1912

Oct. 1, 1911

10-1-11

x

Oct. 1, 1911

Bureau of Fish and Game, Washington, D.C.

Reid, James A.

Scott L. Lincoln & Son, Bakersfield, Cal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11981

CERTIFICATE OF DEATH

11967

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1 22 N. Potomac St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence Osborn Ridenour</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>1961</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 16, 1895</u> 9. AGE (In years last birthday) <u>66 yrs.</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kilburner</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Lime & Cement</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles W. Ridenour</u> 14. MOTHER'S MAIDEN NAME <u>Mary Kriner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u> 16. SOCIAL SECURITY NO. <u>213-10-6811</u>		17. INFORMANT <u>Mrs. Josephine Shaffer</u> Address <u>Hagerstown, Md.</u> <u>926 Lanvale St.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of</u> <u>157X</u> DUE TO (b) <u>Ca of pancreas</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE <u>H.N. Weeks M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>H.N. WEEKS</u>		22b. ADDRESS <u>HAGERSTOWN MD</u> 22d. ADDRESS <u> </u>		22e. DATE SIGNED <u>10/21/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct 22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> 23d. LOCATION (City, town or county) <u>Hagerstown</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>			
25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> DATE <u>OCT 23 '61</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11982

11968

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allaganeys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 218 No Center St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Andrew A. RIDGWAY 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec 4 1884 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH 10 31 1961 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk W.M.R.R. Retired 10b. KIND OF BUSINESS OR INDUSTRY Railway 11. BIRTHPLACE (County & State or foreign country) W. Va. Kabletown Jefferson Co 12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John J. Ridgway 14. MOTHER'S MAIDEN NAME Nannie E. Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 705-10-5664 17. INFORMANT Mrs Coy Dyer 1311 Michigan Ave Cumberland Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM (b) ARTERIOSCLEROTIC HEART DISEASE (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LOBULAR PNEUMONIA - BENIGN NEPHROSCLEROSIS			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 11, 1961 to Oct 31, 1961 that (I) (we) last saw the deceased alive on Oct 31, 1961 and that death occurred at P.M. from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE Antonio U. Pallarosi 22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAROSI				22b. ADDRESS 1500 Penna Ave. Hagerstown, Md. 22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11/3/61 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery 23d. LOCATION (City, town or county) Md (State) Cumberland Allegany Co				24. FUNERAL DIRECTOR'S SIGNATURE George Funeral Home Cumberland Md. 25a. REC'D BY REGISTRAR NOV 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11932

(M)

Williamson

May 1900

George Washington Hospital

The No. 1000 St.

Dec 6 1901

Washington, D.C.

John A. Johnson

John A. Johnson

705-1-2101 The City of Washington

THE MOUNTAIN VIEW

WASHINGTON, D.C.

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WASHINGTON, D.C.

George Washington Hospital

George Washington Hospital

George Washington Hospital

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11983

11969

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>BELL</u> Last <u>Rohr</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR <u>4</u> Months <u>5</u> Days		11. IF UNDER 24 HRS. <u>7</u> Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Liberty, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Arion McFarland</u>				14. MOTHER'S MAIDEN NAME <u>Molly Stuck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT (Son) <u>Joseph Rohr</u> Address <u>Route 4 Keedysville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized Cachexia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10 1961</u> to <u>Oct 23 1961</u> , and that (II) (we) lost saw the deceased alive on <u>Aug 15 1961</u> , and that death occurred at <u>4:00</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Byrkit</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>				22d. ADDRESS <u>Williamsport Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hagerstown Md</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L Leaf</u> ADDRESS <u>Williamsport Md</u>				25a. REC'D BY REGISTRAR <u>Oct 26 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. K...</u>	

(M)

(I)

11383

CERTIFICATE OF DEATH

For State Health Department Registration

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11984											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1005 Pope Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ima May Sampsell						4. DATE OF DEATH October 25 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Funkstown, Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Henry Watson						14. MOTHER'S MAIDEN NAME Monie Aushman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Mrs. W. R. Marshall				Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Women due to nephrosclerosis Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) Chronic sub-acute & Cholelithiasis Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 10/9/61 10/9/61	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct 1 - Oct 25 1961 to Oct 25 1961 , that (I) (we) last saw the deceased alive on Oct 25 1961 , and that death occurred at 2:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Sidney Novenstein M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-25-61			
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN						22d. ADDRESS Funkstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.				
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son						ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 30 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

M

1884

Washington

Washington

Washington

Washington

20 years

Washington County Hospital

100 Popo Ave

Law

Law

October 22

Female wife

Sept. 29, 1888

House wife

Own home

Washington, D.C.

John Henry Watson

John Henry Watson

Mrs. J. R. Watson, Washington, D.C.

Initial

10-28-61

John Hill Cemetery

Washington, D.C.

Scott E. Minnich & Son, Washington, D.C.

Washington, D.C.

Oct 20 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11985 CERTIFICATE OF DEATH 11971											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. LENGTH OF STAY IN 1b <u>Life</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home</u>								d. STREET ADDRESS <u>Hancock Maryland</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Newton</u> Last <u>Seville</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13, 1872</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hancock Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Arthur Seville</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Myers</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220.10.3305</u>				17. INFORMANT <u>Mrs Olive P Seville Hancock Md.</u> Address <u>Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Dignoid</u> <u>153.3</u> DUE TO (b) <u>Ch. Myocardites</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Quemina</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>5728</u> 19 <u>61</u> to <u>Oct 4</u> 19 <u>61</u> that (I) <u> </u> saw the deceased alive on <u>Oct 4</u> 19 <u>61</u> , and that death occurred at <u>7:55</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>L M Shaffer</u>				22b. DATE <u>10/6/61</u>				22c. PHYSICIAN'S NAME (Type) <u>L M SHAFFER</u>			
22d. ADDRESS <u>Hancock Md.</u>				22e. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 10 '61</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10.6.61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>			
23d. LOCATION (City, town or county) <u>Hancock Washington Md.</u>				23e. (State) <u> </u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Leone Hancock Md</u> ADDRESS <u> </u>											

1935

(M)

Handcock

Home

William

1935

Handcock

Handcock

Handcock

Handcock

Handcock

Handcock

Handcock

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
11986
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11972

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Boonesboro, Md -</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lahrney - Keedy Memorial Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u> d. STREET ADDRESS <u>State Line, Pa.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William E. Shindle</u>		4. DATE OF DEATH <u>Oct. 28</u> 19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mason-Dixon, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob R. Shindle</u>		14. MOTHER'S MAIDEN NAME <u>Susan Rice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Charles P. Shindle</u>		Address <u>POC Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Indefinite</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 28, 1961</u> to <u>Oct. 28, 1961</u> , that (II) (we) last saw the deceased alive on <u>Oct. 28, 1961</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED <u>Oct. 30, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	23b. DATE THEREOF <u>10/31/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Wash. Co., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich</u>		25. REC'D BY REGISTRAR <u>NOV 2 '61</u>	
ADDRESS <u>Greencastle, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

11883

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
11987 Item 9 Film G297 10/13/61 ink 11973																			
1. PLACE OF DEATH a. COUNTY Washington				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b D.O.A.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) CURVIN ARTHUR SMITH				4. DATE OF DEATH October 1 1961 19				5. SEX Male				6. COLOR OR RACE white							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH May 16 1910 51 yrs.				9. AGE (In years last birthday) 51 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Costodian, Fountain Head Country Club				10b. KIND OF BUSINESS OR INDUSTRY Club				11. BIRTHPLACE (County & State, or foreign country) Hanover York Co Pa.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Grover C. Smith				14. MOTHER'S MAIDEN NAME Emma G. Springer				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 167-14-3539							
17. INFORMANT Mrs. Christine M. Smith, 25 1/2 W. Franklin St. Address Hagerstown, Maryland.				18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic coronary disease (e), stating the underlying cause last. DUE TO INTERVAL BETWEEN ONSET AND DEATH minutes sev yrs.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 30/12/5 to 1961, that (I) (we) last saw the deceased alive on 30/12/5 1961, and that death occurred at 11:50 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Howard N. Weeks, M.D.				22b. DATE SIGNED OCT 9 '61				22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 N. Potomac St.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/4/61				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md							
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR OCT 9 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

11821

M

1

136 L. Tolman St.

Howard N. Cole, N.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11988

CERTIFICATE OF DEATH

Reg. Dist. No. 11974

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY ELLSWORTH SMITH		4. DATE OF DEATH Month Day Year OCTOBER 8 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/1910
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ASST. CAR FOREMAN RAIL ROAD		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY E. SMITH SR.		14. MOTHER'S MAIDEN NAME SUDA YATES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-10-8643	
17. INFORMANT MRS. THELMA SMITH		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of liver (c) INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935, 19, to 10/5/61, 19, that I last saw the deceased alive on 10/7/61, 19, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/9/61 ACTUAL SIGNATURE [Signature] M.D. 148 M. [Signature] PHYSICIAN'S NAME (Type) SEARL DOUGLAS MD Hagerstown MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/10/61	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman Hagerstown MD		24a. REC'D BY REGISTRAR DATE OCT 11 '61	
24b. REGISTRAR'S SIGNATURE C. J. [Signature]			

CERTIFICATE OF DEATH

1928

(M)

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JANUARY 1, 1883	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTERED	
JANUARY 15, 1928		HOME		1234		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE		PLACE	
J. H. HARRIS		J. H. HARRIS		JANUARY 15, 1928		BALTIMORE, MD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 20 So Mulberry St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																	
3. NAME OF DECEASED (Type or print) VINCENT EDMUND SNOWDEN					4. DATE OF DEATH October 10 1961					5. SEX Male					6. COLOR OR RACE White					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 18 1894					9. AGE (In years last birthday) 67 yrs.					IF UNDER 1 YEAR Months Days					IF UNDER 24 HRS. Hours Min.																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired										10b. KIND OF BUSINESS OR INDUSTRY Penna R.R.										11. BIRTHPLACE (County & State, or foreign country) W. Va. Martinsburg Berkley Co										12. CITIZEN OF WHAT COUNTRY? USA																													
13. FATHER'S NAME Samuel Snowden										14. MOTHER'S MAIDEN NAME Florence Simpson										15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) --										16. SOCIAL SECURITY NO. None										17. INFORMANT Mrs Mayme H. Snowden Address 20 So Mulberry St Hagerstown Md.																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 540.0 DUE TO Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bleeding peptic ulcer. (c) Chronic bronchitis, Diabetes, obesity.										INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr +										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 28 FEB. 1957 to 10 OCT. 1961 , that (I) (we) last saw the deceased alive on 10 OCTOBER 1961 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.																																																											
22a. SIGNATURE Richard T. Binford M.D.										ATTENDING PHYS. XXX MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED 11 OCTOBER, 1961																																							
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.										22d. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 10/12/61										23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery										23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md																													
24 FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman										ADDRESS Hagerstown Md.										25a. REC'D BY REGISTRAR OCT 13 '61										25b. REGISTRAR'S SIGNATURE Arthur S. Kraus																													

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1

Hammerhead
Resolving paper's color
1/2 + 2 cups

Chronic bronchitis; Bacteria; Glaucoma
X

Richard T. Bingham

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11990

11976

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>30 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MD. STATE HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>1213 N. MULBERRY ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDNA FRANCES SNYDER</u>		4. DATE OF DEATH <u>OCT. 1 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>	
13. FATHER'S NAME <u>JOHN W. M. YEATES</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA JANE CLOPPER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>183-12-1932</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THYROID</u> 194X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		17. INFORMANT <u>MR. MELLIN H. SNYDER</u> Address <u>RT#4 HAGERSTOWN MD.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>7-26-</u> 19 <u>61</u> to <u>OCT 1</u> 19 <u>61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>10-1-</u> 19 <u>61</u> , and that death occurred at <u>10:25</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>		22d. ADDRESS <u>1500 Pa Ave Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norment</u> ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 5 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finnes</u>	

1981

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1. The purpose of this study is to determine the effect of the treatment on the growth of the plants. The results of the study are as follows:

2. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

3. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

4. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

5. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

6. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

7. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

8. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

9. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

10. The treatment had a significant effect on the growth of the plants. The plants treated with the treatment showed a significant increase in growth compared to the control group.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11991					11977									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		WASHINGTON			a. STATE		MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN			b. COUNTY		WASHINGTON							
c. LENGTH OF STAY IN 1b		50 YRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		03 HAGERSTOWN							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
WASHINGTON COUNTY HOSPITAL					1115 MT. ETNA RD.									
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE					
First Middle Last			Month Day Year											
BASIL LEROY SOWERS			OCTOBER 13 19 61			MALE			WHITE					
5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH					
						WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2/19/1902					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
RETIRED SILK WEAVER			SILK MILL			VIRGINIA			U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
CASPER LEE SOWERS					ANNIE BELLE RICKARD									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)					16. SOCIAL SECURITY NO. (If yes give year or dates of service)					17. INFORMANT				
NO					215-09-7294					MRS. SARAH SOWERS HAGERSTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 3 Days 20 yrs. 416X DUE TO Conditions, if any, which gave rise to immediate cause (b) Rheumatic Heart Disease 20 yrs. (e), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19														
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work														
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)														
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 10-10 1961, to 10-13 1961, that (I) (we) last saw the deceased alive on 10-13 1961, and that death occurred at 4:30 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Charles F. Hess M.D.														
22b. DATE SIGNED 10-14-61														
22c. PHYSICIAN'S NAME (Type) CHARLES F HESS														
22d. ADDRESS Smithsburg, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)														
23b. DATE THEREOF 10/16/61														
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.														
23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.														
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.														
25a. REC'D BY REGISTRAR DATE OCT 17 '61														
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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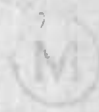
I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11992					11978						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		Washington			a. STATE		Md.				
		MARYLAND			b. COUNTY		Wash.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
rural Smithsburg		16 months			rural Smithsburg						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
RFD 2					RFD 2						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. MONTH DAY YEAR				
First Middle Last					October 24, 19 61						
Betty Jane Stenger											
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
female		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 1, 1924		36 yrs.			
								IF UNDER 1 YEAR IF UNDER 24 HRS.			
								Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
teletype operator					ordance depot		Shippensburg, Penna.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Walter A. Shank					Mae Shoap						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
no					201-18-5206		Paul J. Stenger, Smithsburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant Melanoma with</i> <i>190.9</i> DUE TO <i>Widespread Metastasis</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <i>(Site of original lesion Not Known)</i> DUE TO (c) <i>(Site of original lesion Not Known)</i>										15 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 19, 1960</i> to <i>Oct 24, 1961</i> , that (I) (we) last saw the deceased alive on <i>Oct 23, 1961</i> , and that death occurred at <i>17 M</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Edward W. Ditto III, MD</i>					22b. DATE SIGNED <i>Oct 24, 1961</i>		22c. PHYSICIAN'S NAME (Type) <i>Edward W. Ditto III, M. D.</i>		22d. ADDRESS <i>217 West Washington St. Hagerstown, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>					23b. DATE THEREOF <i>10-27-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Shippensburg, Pa.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Scott F. Minnich & Son, Hagerstown, Md.</i>					25a. REC'D BY REGISTRAR <i>Oct 27 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

11392

Washington



Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

Funeral 10-27-61 - Spring Hill Cemetery

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11993 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11979

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 22 No Potomac St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JUDY ELAINE STINE			4. DATE OF DEATH Month Day Year October 28 1961 19		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Apr 11 1961		9. AGE (in years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lloyd A. Stine		14. MOTHER'S MAIDEN NAME Marjorie Winck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Marjorie Winck 22 No Potomac St Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 936.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH Several minutes					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child crawled through railing of bed and hung by it's head.		
20c. TIME OF INJURY Month, Day, Year Hour 3:40 p. m. 10-28-1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.			DATE SIGNED 10-30-61		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/61		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE 131 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

(S)

1. Name of Deceased: JOHN J. HARRIS

2. Age: 45 Years

3. Sex: Male

4. Race: White

5. Date of Death: April 11, 1923

6. Place of Death: Home

7. Cause of Death: Myocardial Infarction

8. Duration of Illness: 24 hours

9. Name of Physician: Dr. J. H. Harris

10. Name of Medical Examiner: Dr. J. H. Harris

11. Signature of Medical Examiner: [Signature]

12. Date of Examination: April 11, 1923

13. Place of Examination: Home

14. Name of Hospital: None

15. Name of Doctor: Dr. J. H. Harris

16. Name of Nurse: None

17. Name of Undertaker: None

18. Name of Burial Place: None

19. Name of Burial Date: None

20. Name of Burial Place: None

21. Name of Burial Date: None

22. Name of Burial Place: None

23. Name of Burial Date: None

24. Name of Burial Place: None

25. Name of Burial Date: None

26. Name of Burial Place: None

27. Name of Burial Date: None

28. Name of Burial Place: None

29. Name of Burial Date: None

30. Name of Burial Place: None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11994											
11080											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 2435 Jefferson Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BARBARA ANN SWARTZ						4. DATE OF DEATH October 9, 1961					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1942		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist				10b. KIND OF BUSINESS OR INDUSTRY Sand Blasting Eq. Manufacturer		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert S. Swartz						14. MOTHER'S MAIDEN NAME Arlene Kendle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-40-4186		17. INFORMANT Robert S. Swartz Address Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Abscesses of Peritoneum DUE TO (b) Peritonitis, Generalized DUE TO (c) (Probable) Appendicitis, Acute w/ Perforation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1961 to Oct. 9, 1961 , that (I) (we) last saw the deceased alive on Oct 9, 1961 , and that death occurred at 2:50 P.M. from the causes and on the date stated above. 22a. SIGNATURE Richard V. Hauver M.D. 22c. PHYSICIAN'S NAME (Type) Richard V Hauver M.D. 22b. DATE SIGNED Oct. 10, 1961 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/12/1961 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Md. 25a. REC'D BY REGISTRAR Oct 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes											

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Washington

Washington

Washington County Hospital

Washington

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Washington

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White

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Robert E. White

Robert E. White

Robert E. White

Robert E. White

Robert E. White

Richard E. White

Richard E. White

Richard E. White

Richard E. White

Richard E. White

Richard E. White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11995

CERTIFICATE OF DEATH

11961

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b UNKNOWN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2302 Virginia Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 2302 Virginia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) NORMAN First O. Middle TERPENING Last				4. DATE OF DEATH October 25 1961 Month October Day 25 Year 1961															
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1877		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 5 Days 15		IF UNDER 24 HRS. Hours 5 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm				11. BIRTHPLACE (County & State, or foreign country) Summit, New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jerome Terpenning				14. MOTHER'S MAIDEN NAME Mary Etta Fox															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. J. Logan Treadwell, Jefferson, N.Y. Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) carcinoma of prostate												INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from July 1956 to Oct 1961 , that (I) (last) saw the deceased alive on Sept 15 1961 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Joseph C. Crisp M.D. M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 25, 1961	
22c. PHYSICIAN'S NAME (Type) Joseph C. Crisp M.D.												22d. ADDRESS 115 King Street Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF October 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Jefferson Evergreen Cemetery				23d. LOCATION (City, town or county) (State) Jefferson, N.Y.									
24. FUNERAL DIRECTOR'S SIGNATURE G.O. Fuss & Son ADDRESS Taneytown, Maryland						25a. REC'D BY REGISTRAR Oct 27 '61 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kline											

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11995

Washington

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2302 Virginia Avenue

WYOMING

State

Legation

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Washington

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2302 Virginia Avenue

WYOMING

State

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11996														
11982														
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 520 Guilford Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) FRANK HENRY WADE					4. DATE OF DEATH October 9 1961 19									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5 1886 75 yrs.		9. AGE (In years last birthday) 75						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Warehouse Foreman W.M.R.R.					10b. KIND OF BUSINESS OR INDUSTRY Waynesboro Franklin Co		11. BIRTHPLACE (County & State, or foreign country) Pa USA							
12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Charles Wade					14. MOTHER'S MAIDEN NAME Mary Routzan									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Pearl Brown Wade 520 Guilford Ave Hagerstown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Chemia DUE TO (b) Chronic psychroclerom DUE TO (c) Arteriosclerotic C-V disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis INTERVAL BETWEEN ONSET AND DEATH 3 wks Unknown Unknown														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug 3 19 61 to Oct 9 19 61 , that (I) (we) last saw the deceased alive on Oct 9 19 61 , and that death occurred 10/13/61 from the causes and on the date stated above.														
22a. SIGNATURE L. L. Packen Jr MD					22b. DATE SIGNED 10/11/61									
22c. PHYSICIAN'S NAME (Type) L. L. Packen Jr MD					22d. ADDRESS Hagerstown, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/13/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md						
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.					25a. REC'D BY REGISTRAR DATE OCT 13 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus							

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12
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11983											
1. PLACE OF DEATH e. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MD. STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK d. STREET ADDRESS 344 CATOCTIN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Campbell Weedy						4. DATE OF DEATH Month Day Year October 25, 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-1870		9. AGE (in years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME GEORGE CAMPBELL						14. MOTHER'S MAIDEN NAME DO NOT KNOW					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Name Address GEORGE R. WEEDY FREDERICK MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of hip, left (c) Fracture of hip, left DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 6 days 5 mos.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. twisted left leg and sustained a fracture of left hip							
20c. TIME OF INJURY Month, Day, Year Hour 5:00 p.m. May 30, 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Fredrick, Frederick, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (Type) Dr. F. W. Hall						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1739/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10-27-61		22c. NAME OF CEMETERY OR CREMATORY BURKITTSVILLE		22d. LOCATION (City, town, or county) (State) BURKITTSVILLE MD			
23. FUNERAL DIRECTOR ADDRESS Chas. Hub Brunswick, Maryland						24a. REC'D BY REGISTRAR DATE OCT 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11007

(M)

George Campbell
Female White
8-2-1870
Best preserved
In my collection

(T)

George Campbell
Female White
8-2-1870
Best preserved
In my collection

George Campbell
Female White
8-2-1870
Best preserved
In my collection

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11998

CERTIFICATE OF DEATH

11984

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Yr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 148 Donnybrook Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 148 Donnybrook Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN CARL WHITE M. D.		4. DATE OF DEATH Month Day Year October 27 1961				
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14 1921	9. AGE (In years last birthday) 39 rs.	IF UNDER 1 YEAR Months Days 39	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Book Lane Farm		11. BIRTHPLACE (County & State, or foreign country) Omaha Douglas Co Neb.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carl White		14. MOTHER'S MAIDEN NAME Hazel Lake				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.#2 507-10-7444		17. INFORMANT Mrs Olga L. White 148 Donnybrook Dr		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1561 IMMEDIATE CAUSE (a) adenocarcinoma of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 3+ months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3 APR. 1961 to 27 OCT. 1961 , that (I) (we) last saw the deceased alive on 27 OCT. 1961 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.						
22a. SIGNATURE Richard T. Binford M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		22d. ADDRESS 1135 POTOMAC AVENUE				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR OCT 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. ...

MEDICAL CERTIFICATION

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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0977

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11985											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Berkeley c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg Rt. # 2 d. STREET ADDRESS (Bedington)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HUGH EDMOND WILLINGHAM				4. DATE OF DEATH OCTOBER 21 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Bunker Hill, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Willingham				14. MOTHER'S MAIDEN NAME Mary C. Mayhew							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Fred Rice - Martinsburg Rt. # 2 W. Va.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY ATHEROSCLEROSIS SEVERE DUE TO THROMBOSIS RIGHT CORONARY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY CONGESTION DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 10 YRS RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE DR. E.W. DITTO, JR.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) DR. E.W. DITTO, JR.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10/27/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-24-1961		22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) Martinsburg, West Virginia			
23. FUNERAL DIRECTOR H. K. BROWN						ADDRESS Martinsburg, W. Va.		24a. REC'D BY REGISTRAR Oct 24 '61		24b. REGISTRAR'S SIGNATURE Clifford S. Huns	

11992

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(Continued)

January 1972

Dr. J. C. Brown

CHRONIC ATHEROSCLEROSIS SEVERE
THROMBOSIS RIGHT CHRONIC
PULMONARY CONGESTION

DR. E.W. DITTO, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12000

11986

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 400 Reynolds Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY CATHERINE WINDER				4. DATE OF DEATH October 13 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1874		9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Poffenberger				14. MOTHER'S MAIDEN NAME Julia A. Rohrer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Charles Poffenberger Address Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Hypertensive Crisis DUE TO (c) Complications from Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 4 days 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-1-61, 19 to 10-13, 1961, that (I) (we) last saw the deceased alive on 10-13-61, and that death occurred at 6:30 P.M., from the causes and on the date stated above.									
22a. SIGNATURE [Signature]				22b. DATE SIGNED [Signature]		22c. PHYSICIAN'S NAME (Type) Dr. E. W. H. T. Jr.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/15/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REC'D BY REGISTRAR OCT 18 '61		25b. REGISTRAR'S SIGNATURE [Signature]			

(M)

10000

Washington

Washington

State

Washington

Washington County Hospital

100 Reynolds Ave.

NAME

CHARLES A. HOLLMAN

October 15

Female

White

January 5, 1914

Hagerstown

Hagerstown, Maryland

Charles A. Hollman

John A. Hollman

none

Dr. Charles Hollman, Hagerstown, Md.

(I)

Birth 10/12/1901 Rose Hill Cemetery Hagerstown, Maryland

Death - 10/15/1914 Hagerstown, Maryland (21)

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G297 10/20/61 iwk.

12001

CERTIFICATE OF DEATH

Reg. Dist. No.

11987

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL HAGERSTOWN		d. STREET ADDRESS Rt. 2, Nursery Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIEL Middle WEBSTER Last WOLFINGER		4. DATE OF DEATH Month OCTOBER Day 6 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/1885
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER M. WOLFINGER		14. MOTHER'S MAIDEN NAME SOPHIA J. LAMBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT MR. LAWSON WOLFINGER		Address: HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c) 4 yrs.			INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19____, to Oct 6 , 19 61 , that I last saw the deceased alive on Oct 6 , 19 61 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown Md. DATE SIGNED Oct 7, 61			
ACTUAL SIGNATURE Clayton A. Hoffner M.D.		DATE SIGNED Oct 7, 61	
PHYSICIAN'S NAME (Type) Clayton A. Hoffner		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/9/61	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR DATE OCT 11 '61	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. H.	

Item 11-21-61 301 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12002

CERTIFICATE OF DEATH

11988

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b most of life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 707 Salem Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY LORAIN YOUNG			4. DATE OF DEATH October 14 19 61				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 7, 1911	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 14 Days 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Doctor's office		11. BIRTHPLACE (County & State, or foreign country) Thomasville, N. Carolina			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Luther Sharman Black			14. MOTHER'S MAIDEN NAME Mary Jane Black				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-1009		17. INFORMANT Mr. B. Franklin Young Address Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Hypertension encephalopathy IMMEDIATE CAUSE (a) 331 X DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Complications of cerebral edema tonsillar herniation with respiratory failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE <i>W. Ross Cameron</i> M.D.			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) W. ROSS CAMERON		
22d. ADDRESS Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/16/1961	23c. NAME OF CEMETERY OR CREMATORY Keeseltown Cemetery	23d. LOCATION (City, town or county) Keeseltown,	(State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Meyer</i>			ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR Oct 18 '61	25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

12002



Washington

Washington

Washington

Washington

Washington

Washington

Washington County Hospital

707 Salem Ave.

RAY

CLARENCE

YOUNG

October

1911

Female White

September, 1911

Doctor's Office

Thomasville, Georgia

Secretary

Walter Stewart Black

Ray and Black

21-02-1-00

no

Washington County Hospital



Handwritten signature and text, mostly illegible.

Handwritten signature and text, mostly illegible.

10/16/1911

Washington Cemetery

Washington

Washington

Inter - Lower Central

Inter - Lower Central

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

12

Dr. Ditto

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
11989									
1. PLACE OF DEATH e. COUNTY WASHINGTON f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOONSBORO d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) X BOONSBORO HIGH SCHOOL					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE MARYLAND f. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X GAPLAND 'RURAL' d. STREET ADDRESS 1 GAPLAND MD.				
3. NAME OF DECEASED (Type or print) EDGAR LEON YOUNKINS					4. DATE OF DEATH OCTOBER 17 1961				
5. SEX MALE					6. COLOR OR RACE WHITE				
7. MARRIED X NEVER MARRIED WIDOWED DIVORCED					8. DATE OF BIRTH MARCH 10 1906 55 yrs.				
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN - BOONSBORO HIGH SCHOOL					9b. KIND OF BUSINESS OR INDUSTRY BROWNSVILLE WASH. CO. MD. U.S.A.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN - BOONSBORO HIGH SCHOOL					10b. KIND OF BUSINESS OR INDUSTRY BROWNSVILLE WASH. CO. MD. U.S.A.				
11. BIRTHPLACE (State or foreign country) BROWNSVILLE WASH. CO. MD. U.S.A.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME MORSE A. YOUNKINS					14. MOTHER'S MAIDEN NAME ANNA FOUCHE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) NO.					16. SOCIAL SECURITY NO. 212-01-8252				
17. INFORMANT MRS. MAUDIE YOUNKINS					Address GAPLAND MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Chronic Rheumatic Heart Disease With Mitral Insufficiency DUE TO (b) Myocardial Fibrosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE A. E. Smith					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 10-18-61				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF OCT-19-1961				
22c. NAME OF CEMETERY OR CREMATORY BROWNSVILLE CEMETERY					22d. LOCATION (City, town, or country) (State) BROWNSVILLE WASH. CO. MD.				
23. FUNERAL DIRECTOR John H. Bast					24a. REC'D BY REGISTRAR OCT 24 '61				
24b. REGISTRAR'S SIGNATURE C. L. H. H. H.									

12003

RECORDS SECTION, DEPARTMENT OF HEALTH

11-11-41

11-11-41